BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:	)	
Stanley Schwartz, M.D.	)	**File No. 800-2014-002348**
Physician's and Surgeon's Certificate No. A42271	)	
Respondent	)	

DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on January 5, 2018.

IT IS SO ORDERED December 7, 2017.

MEDICAL BOARD OF CALIFORNIA

By: Kristina Lawson

Kristina Lawson, Chair
Panel B

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: STANLEY SCHWARTZ, M.D., Physician's and Surgeon's Certificate No. A42271, Respondent.	Case No. 800-2014-002348 OAH No. 2017031119

PROPOSED DECISION

Theresa M. Brehl, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on September 25, 26, 27, 28, and 29, and October 6, 2017, in San Diego, California.

Christine A. Rhee, Deputy Attorney General, Department of Justice, State of California, represented complainant Kimberley Kirchmeyer, Executive Director, Medical Board of California, Department of Consumer Affairs, State of California.

Steven H. Zeigen, Rosenberg, Shpall & Zeigen, PLC, represented respondent Stanley Schwartz, M.D.

The matter was submitted on October 6, 2017.[1]

[1] The parties were ordered to redact patients' identifying information from exhibits before they would be received in evidence, and the record was held open until October 6, 2017, to allow the parties time to do so. Because redaction of patients' names and other identifying information would adequately protect the patients' confidentiality in this public proceeding, the parties' motions for protective orders to seal all exhibits containing patients' medical information were denied, with the exception of a patient interview video which was placed under seal. Additionally, complainant's motion to amend the accusation was granted, and complainant submitted the first amended accusation on October 4, 2017. On October 6, 2017, redacted versions of records were received in evidence and the first amended accusation was received as a jurisdictional document. Respondent's counsel made no additional arguments regarding the first amended accusation, and the case was submitted.

SUMMARY

Complainant sought to discipline Dr. Schwartz's physician's and surgeon's certificate based on allegations regarding Dr. Schwartz's treatment and care of three patients. Complainant asserted Dr. Schwartz committed gross negligence when he prescribed controlled substances to two of those three patients; committed repeated negligent acts when he prescribed controlled substances to all three patients; engaged in general unprofessional conduct demonstrating an unfitness to practice medicine; and failed to maintain adequate and accurate medical records regarding his care and treatment of one of the three patients.

Complainant's contentions were based on the opinions of an expert reviewer whose written report did not discuss the medical conditions Dr. Schwartz was treating and inappropriately used suggestions contained in the board's *Guidelines for Prescribing Controlled Substances for Pain,* November 2014 Revision (*Prescribing Guidelines*), as the standard of care. During the instant hearing, complainant's expert continued to point to the *Prescribing Guidelines* when answering questions about the standard of care; acknowledged that some of the reasons he articulated in his report and during his testimony as supporting his opinions were not actually required by the standard of care; conceded that some of the information he relied on in his report was inaccurate; and contradicted himself several times while testifying. Respondent's expert witness, on the other hand, understood his role as an expert to define the applicable standard of care; clearly articulated the standard of care applicable to Dr. Schwartz's treatment and care of the three patients at issue; and credibly testified in an objective manner that Dr. Schwartz did not depart from the applicable standard of care in his treatment and care of the three patients. Dr. Schwartz's expert also opined that some of Dr. Schwartz's medical records, which were generated before Dr. Schwartz converted to electronic medical records, did not meet the standard of care for maintaining adequate medical records.

Complainant failed to prove by clear and convincing evidence that Dr. Schwartz engaged in gross negligence, repeated negligent acts, or general unprofessional conduct. Complainant proved by clear and convincing evidence that Dr. Schwartz failed to maintain adequate medical records for one patient between 2010 and 2013.

Based on the evidence presented, a period of probation and supervision, which complainant sought during closing argument, is not necessary to protect the public. The evidence established that Dr. Schwartz's record keeping improved significantly after he converted to electronic medical records. Therefore, the appropriate discipline in this matter is a public reprimand with an order requiring Dr. Schwartz to complete a medical record keeping course.

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FACTUAL FINDINGS

Licensing and Jurisdictional Background

1. On November 12, 1985, the board issued Physician's and Surgeon's Certificate No. A42271 to Dr. Schwartz. His certificate was in full force and effect at all times relevant to this proceeding and will expire on June 30, 2019, unless renewed. There have been no prior disciplinary actions against Dr. Schwartz's certificate.

2. Complainant signed the accusation on January 12, 2017, and respondent timely submitted a notice of defense. Complainant signed the first amended accusation on October 4, 2017. The first amended accusation included allegations dating back to 2004. However, complainant's pleading clearly stated in a footnote that any conduct occurring more than seven years before the filing of the initial accusation was only alleged for informational purposes and was not alleged as the basis for any discipline.[2] While Dr. Schwartz's treatment and care of the patients before 2010 may not be the basis for discipline, information about such prior treatment was important to understand the patients' medical conditions and the treatments they had already tried to alleviate their pain before the relevant timeframes.

The amended pleading alleged Dr. Schwartz committed gross negligence in his care and treatment of two patients, J.S. and G.S. (First Cause for Discipline); committed repeated negligent acts in his care and treatment of patients J.S., G.S., and E.G. (Second Cause for Discipline); engaged in conduct that breached the rules or ethical code of the medical profession or which was unbecoming of a member in good standing of the medical profession, and which demonstrated an unfitness to practice medicine, in his care and treatment of patients J.S., G.S., and E.G. (Third Cause for Discipline); and failed to maintain adequate and accurate medical records in his care and treatment of patient J.S. (Fourth Cause for Discipline).[3]

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[2] See Business and Professions Code section 2230.5, subdivision (a), which states: "Except as provided in subdivisions (b), (c), and (e), any accusation filed against a licensee pursuant to Section 11503 of the Government Code shall be filed within three years after the board, or a division thereof, discovers the act or omission alleged as the ground for disciplinary action, or within seven years after the act or omission alleged as the ground for disciplinary action occurs, whichever occurs first."

[3] The Fourth Cause for Discipline is limited to the time frame from January 2010 through 2015, as it refers back to paragraphs 9 through 17, and the allegations in those paragraphs before January 2010 may not be grounds for discipline in this matter pursuant to Business and Professions Code section 2230.5, subdivision (a).

The first amended accusation alleged Dr. Schwartz prescribed controlled substances without developing and documenting adequate treatment plans and objectives; without conducting ongoing review and monitoring while prescribing opioids for extended periods of of time; and without consulting specialists and/or abiding by recommendations from specialists. The first amended accusation alleged Dr. Schwartz:

- Prescribed patient J.S. the following medications during the time period from January 22, 2010, through July 14, 2015:
    - Hydromorphone (a schedule II controlled substance also referred to under the brand name Dilaudid), and
    - Morphine Sulfate (a schedule II controlled substance also referred to under the brand name MS Contin);
- Prescribed patient G.S. the following medications during the time period from February 7, 2011, through December 10, 2012:
    - Fentanyl (a schedule II controlled substance also referred to under the brand name Duragesic),
    - Morphine (a schedule II controlled substance also referred to under the brand name Kadian),
    - Diazepam (a schedule IV controlled substance also referred to under the brand name Valium),
    - Hydromorphone (a schedule II controlled substance also referred to under the brand name Dilaudid),
    - Norco (Norco is a brand name for a combination of hydrocodone and acetaminophen. Hydrocodone is a schedule II controlled substance),
    - Lorazepam (a schedule IV controlled substance also referred to by the brand name Ativan),
    - Oxycodone (a schedule II controlled substance also referred to by the brand name Oxycontin), and
    - Alprazolam (a schedule IV controlled substance also referred to by the brand name Xanax);

- Prescribed Patient E.G. the following medications during the time period from January 11, 2012, through December 22, 2013:
    - Norco (Norco is a brand name for a combination of hydrocodone and acetaminophen. Hydrocodone is a schedule II controlled substance),
    - Oxycodone (a schedule II controlled substance also referred to by the brand name Oxycontin),
    - Amphetamine (a schedule II controlled substance also referred to under the brand name Adderall),
    - Zolpidem (a schedule IV controlled substance also referred to under the brand name Ambien), and
    - Alprazolam (a schedule IV controlled substance also referred to by the brand name Xanax).

Stanley Schwartz, M.D.'s Medical Background and Practice

3. Dr. Schwartz attended California State University from 1974 through 1976, and the University of Southern California from August 1976 through June 1978, and he was awarded a Bachelor of Arts Degree in Speech Communications in 1978. Dr. Schwartz attended medical school at Universidad de Juarez, Mexico, from 1978 through 1980 and University of Dominica (also known as Ross University) from 1981 through 1982, and he was awarded his medical degree in 1982. Dr. Schwartz performed his internship in internal medicine (1982 to 1983) and his residency in internal medicine and pediatrics (1983 to 1986) at The New York Medical College, Metropolitan Hospital Center. He is board certified in internal medicine and pediatrics.

4. Dr. Schwartz currently has hospital privileges at Riverside Community Hospital and Parkview Community Hospital, which are both located in Riverside, California. He has been affiliated with various hospitals over the past 32 years, and his hospital privileges have never been suspended or revoked. He was Chief of Staff at San Gorgonio Hospital from 2001 through 2003, and Chief of Community Medicine at Moreno Valley Community Hospital from 2004 to 2006. Dr. Schwartz stopped practicing at Moreno Valley Community Hospital after it was purchased by Kaiser Permanente and then only worked with doctors affiliated with Kaiser. He no longer practices at San Gorgonio Hospital because it lacks specialty care and he does not believe it is medically safe to practice there.

5. Dr. Schwartz has been in private practice for approximately 25 years; he is the sole owner of his practice; and he currently has three locations in Riverside, Moreno Valley, and Banning, California. He is a primary care physician. He treats patients from "cradle to grave," and his patients include multi-generational families. He serves a diverse population, with patients from every walk of life. He currently employs 55 people, including five nurse

practitioners, two physician assistants, one internist, and one pediatrician. Pediatrics is approximately 60 percent of his practice; adults are the remaining 40 percent; and of the adult patients, 15 percent are over 50 years old and 10 percent are over 60 years old. He has about 18,000 patients, with 14,000 in managed care and 4,000 with preferred provider (PPO) insurance plans. From 2010 to 2016, pain management comprised about five percent of his practice, including patients J.S., G.S., and E.G.

6. Most of Dr. Schwartz's patients live in the Banning and Beaumont area, with a population of approximately 50,000. Specialists are very limited in that area. Some of Dr. Schwartz's patients have transportation issues, including J.S., G.S., and E.G., because many of them do not drive.

7. In addition to his private practice, Dr. Schwartz has served as the medical director of a skilled nursing home, Banning Convalescent; four hospice care facilities, Health Essential Hospice, Shangri-La Hospice, Health Essentials Hospice, and 365 Hospice, Inc.; and two residential care providers for the severely disabled, Independent Options and New Ideals (which has four facilities). He is currently the medical director for 365 Hospice, Inc., New Ideals, and Independent Options. He has never been asked to resign from a medical director position, and his duties as a medical director account for less than five percent of his work. He considers his work for the adult disabled facilities to be virtually uncompensated because he receives approximately $12 for each patient visit. He sees disabled adult patients every month, he is available any hour for advice, and he sometimes treats those patients in the hospital. The hospice medical director work is a collaborative effort to help patients transition through the end of life.

8. According to Dr. Schwartz, palliative care may be provided in a hospice setting or outside a hospice setting. Palliative care is always a part of hospice to try to control pain, anxiety, and bodily functions as the patients are dying. Palliative care outside of hospice involves trying to alleviate symptoms, such as pain, anxiety, bodily functions, and sleep disorders, so the patient may function better.

Dr. Schwartz's Handling of Pain Management Patients

9. Dr. Schwartz's training in pain management during his residencies included rotations in detox, physical medicine, and anesthesiology. More recently, he attended a three-day national pain forum in 2005 and a geriatric board review at the University of California Los Angeles in 2007. He took the University of California San Diego, Physician Assessment and Clinical Education Program (PACE), Physician Prescribing Course in April 2017.

10. The CURES[4] became available to monitor prescriptions in 2005, and Dr. Schwartz started to use it immediately to monitor his patients' medications. However, the CURES reports were not printable until more recently. He did not document every time he reviewed CURES because there was no reason to do so if he did not find anything from his review. He has dismissed patients when he found problems from a CURES review, but he had no such problems with J.S., G.S., or E.G. Inland Empire Health Plan (IEHP) Member Histories, which contain similar prescription information to CURES, were available for patients with coverage through IEHP, including G.S. and E.G., and Dr. Schwartz routinely printed IHEP member histories and reviewed them to see patients' prescription histories. J.S. was not an IEHP patient.

11. Not all the prescriptions Dr. Schwartz gave patients were filled because sometimes the pharmacies were unable to fill them for various reasons, and Dr. Schwartz sometimes needed to write new prescriptions in place of the ones that could not be filled. Therefore, he believed the IHEP member histories and/or CURES provided a more accurate account of the medications dispensed to patients than copies of his written prescriptions.

12. Dr. Schwartz has used pain management contracts since the early 2000s, using a template he obtained from a pharmaceutical company. He tries to have every patient sign one. He has also been doing random drug screens for several years.

13. Dr. Schwartz explained that it has been his practice to discuss treatment goals with his patients and he will jot down little notes about what was discussed. But he is not a stenographer, and it is not possible for him to document everything that is discussed. Since he switched to electronic medical records in late 2011 and early 2012, he has found it easier to document his medical care and treatment of patients, and his records have become more legible.

Undercover Operation

14. During 2015, the board sent a patient to Dr. Schwartz's practice during its investigation who Dr. Schwartz later learned was part of an undercover operation. That patient complained of fatigue and asked Dr. Schwartz to prescribe Hydrocodone or Norco. He told Dr. Schwartz he wanted the medication because it made him "feel good." Dr. Schwartz refused to prescribe the requested medication because there was no medical indication for it. No charges regarding this "patient" were ever alleged by complainant.

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[4] The Controlled Substance Utilization Review and Evaluations System (CURES) is a database of all Schedule II, III, and IV controlled substance prescriptions dispensed in California. (See Health & Saf. Code, § 11165 et seq.)

Dr. Schwartz's Treatment of Patients J.S., G.S., and E.G.

PATIENT J.S.[5]

15. Dr. Schwartz testified about his treatment of J.S. and her medical records were received in evidence. Additionally, Patient J.S. provided a written declaration, dated June 28, 2017, and was interviewed on videotape.[6]

16. J.S. is a 70-year-old widow, she lives in Beaumont, California, and she is a retired Child Protective Services' social worker. J.S. suffered from trigeminal neuralgia and had a history of failed cervical neck surgery when Dr. Schwartz started to treat her. According to Dr. Schwartz, trigeminal neuralgia has been nicknamed the "suicide disease" because 25 percent of patients commit suicide, which is two times the national suicide rate. J.S. began seeing Dr. Schwartz in early 2006, after she changed her insurance coverage so she could obtain care from a neurosurgeon at UCLA, named Dr. Neil Martin, for the pain she was suffering. That treatment included brain surgery to implant a device to help alleviate the pain, but the procedure was not successful. Post surgery, she also had mastoid pain at the surgical site.

17. When Dr. Schwartz began seeing J.S., she had already tried non-opioid treatment, including anti-seizure medication and Botox injections. Before seeing Dr. Schwartz, J.S. had been prescribed opioids by other doctors and she was already opioid dependent.

18. J.S. described her medical history before seeing Dr. Schwartz in her declaration as follows:

> Prior to becoming Dr. Schwartz's patient, I had experienced years of treatment with other physicians. I have had surgeries stabilizing my cervical spine on three different occasions beginning at age 21 years. It was unknown why my spine was so unstable as I never had any previous injuries. As a result of these procedures, I developed a condition classically diagnosed as Trigeminal Neuralgia. After extensive non-surgical treatment and interventions over many years, I was referred to UCLA by a

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[5] The first amended accusation alleged that Dr. Schwartz's treatment of J.S. from January 22, 2010, through July 14, 2015, provided cause to discipline his certificate. Consideration of J.S.'s treatment before January 22, 2010, was important to understand J.S.'s condition and pain relief treatments she had received before the time period at issue.

[6] J.S.'s declaration testimony and videotaped interview were received in evidence as administrative hearsay and were considered to the extent they supplemented and explained other admissible evidence. (Gov. Code, § 11513, subd. (d).)

> neurologist to undergo a "risky" procedure. In my desperation to be functional in my profession, I submitted to a procedure called a Microvascular Decompression. It seemed to improve my trigeminal condition about eighty per cent [*sic*] until a vehicular mishap with my husband as the driver, exacerbated both the Trigeminal nerve pain and the surgical site discomfort. Immediately after I was seen again by Dr. Martin, he recognized that I needed another procedure and he scheduled me for surgery. Dr. Schwartz medically cleared me for this surgery in January 2006.

19. After J.S. had the surgery at UCLA in January 2006, she remained in the hospital for two weeks on a Dilaudid pump. When she was discharged, an UCLA anesthesiologist and pain specialist prescribed J.S. with Diluadid 8 mg, one tablet every three hours, and morphine extended release 60 mg, three times a day.

20. In March of 2006, Dr. Schwartz referred J.S. to see a pain specialist in Banning, California, Andrew Thio, M.D. Dr. Thio discontinued the Dilaudid, placed J.S. on Fentanyl patches, and prescribed Norco for breakthrough pain. Dr. Thio also performed a spinal cord stimulator trial surgical procedure on June 13, 2006, in an attempt to alleviate J.S.'s pain, which was not successful. Dr. Thio recommended that J.S. switch to Methadone, which she declined because she associated Methadone with heroin users.

21. In 2007, Dr. Thio closed his Banning office. In order to continue seeing him, J.S. would have needed to travel 50 miles to his office in Temecula, California. J.S. did not drive and her husband was unable to take time off work to drive her there every month. Because there were no local options, J.S. then asked Dr. Schwartz to handle her pain management treatment. According to J.S.'s declaration testimony, Dr. Schwartz has prescribed the following pain medications to her since 2007:

> Initially, Dr. Schwartz started me on Norco 10/325 every four hours. On subsequent visits with my input, we eventually settled on Dilaudid 8 mg which was previously more effective. I needed about 10 pills per day, roughly every 2-3 hours to quell the pain. This dosage remained for the next seven years. In December 2009, due to manufacturing reasons, at that time, I could not get the 8 mg strength, so I was forced to get "double" the amount of the 4 mg strength, approximately 600 pills per month.
>
> In January 2014, my insurance would no longer cover Dilaudid. Dr. Schwartz switched me to Morphine 30 mg every three hours. It was not as effective as the Dilaudid.
>
> [¶] . . . [¶]

My dose of Morphine 30 mg every 3 hours, 240 pills, has remained to this day without adverse events.

22. Dr. Schwartz explained that when he prescribed J.S. the Dilaudid, he calculated the morphine equivalent dosage, and he determined the amount he was prescribing was a safe dosage for an opioid tolerant patient. He later switched her to morphine from Dilaudid because the Dilaudid was no longer on the formulary for her insurance coverage. Dr. Schwartz then determined the morphine equivalency for the morphine, and he determined the amount of morphine he prescribed J.S. was not excessive for an opioid tolerant person.

23. Every time Dr. Schwartz saw J.S., he talked to her about her pain, and he asked her if there were any changes in the frequency and intensity of her pain. Between 2010 and 2013, Dr. Schwartz saw no reason to document those discussions because her condition was not changing. If something significant had changed, he would have documented it.

24. Before 2012, Dr. Schwartz used handwritten records. From 2010 through 2011, the records reflected that J.S. had offices visits with Schwartz on March 29, 2010, January 6, 2011, March 4, 2011, July 7, 2011, July 19, 2011, and December 7, 2011. While Dr. Schwartz used office visit forms which included spaces for specific information regarding a patient's pain, he did not use the spaces provided on the forms to document detailed pain information. For example, on the March 29, 2010, office visit form, he noted "pain" and "neuralgia" in the area for "clinical impression"; "legs getting stiff" under HPI (history of present illness); circled "moderate" after the space on the form regarding "no acute distress"; and listed J.S.'s Dilaudid prescription under "current meds." The January 6, 2011, May 4, 2011, July 7, 2011, and December 7, 2011, office visit forms similarly noted J.S.'s chronic pain and trigeminal neuralgia and that she was currently prescribed Dilaudid, but no other information was noted about her pain.

25. After Dr. Schwartz switched to electronic medical records in 2012, his records were more legible, but they did not have as much detail during 2012 as they did during later years. For example, when he saw J.S. on June 28, 2012, the office visit record listed opioid dependence, headache, and other facial nerve disorders as the medical problems and impressions, and noted that J.S. was taking Dilaudid. The record did not mention trigeminal neuralgia, and the only specific mention of pain were notes which read, "[s]ome joint pains in in [*sic*] extremities" and "complains of joint pain." The record from J.S.'s December 20, 2012, office visit listed J.S.'s medical problems as including trigeminal neuralgia, other facial nerve disorders, headache, and opioid dependence. The only mention of pain in that record appeared under the history of present illness and stated, "having more pain."

26. There were notes in J.S.'s records regarding her desire to try to stop using opioids. The December 5, 2013, office visit record noted under the history of present illness, "[p]atient wants to get herself off of dependence of pain medications. Lo management in the past but she now wants to try to reduce, she still has pain." At the time, she was taking

Dilaudid 4 mg, 2 tablets every two hours. Under the heading "Pain Assessment," the records stated: "denies any pain although she marked it on paper, states its [*sic*] not bad." On December 6, 2013, Dr. Schwartz referred J.S. to Inland Pain Center. The referral form listed her diagnoses as "Neuralgia, Trigeminal," "Headache," and "Opioid Dependence," and noted the reason for the referral as: "Really needs additional treatment palliative care or place to reduce meds." Dr. Schwartz determined after this referral that there were no treatment centers that could provide J.S. both palliative care and help her with detoxification.

27. J.S. saw Dr. Reynolds at Inland Pain Medicine on January 23, 2014. Dr. Reynolds sent a written report to Dr. Schwartz, summarizing J.S.'s history of present illness as follows:

> [T]his is a 66-year-old female with a chief complaint of trigeminal neuralgia and right sided posterior head pain and neck pain. She reports that all of this pain she has had for many years. She reports that she does not had [*sic*] the pain from the trigeminal neuralgia on the right side of her face in more than six months. However, she reports that the pain indicated over the right mastoid region is present constantly. She reports that the pain ranges from 5/10 to 8/10 in severity on a Visual Analog Pain Scale. It is non-radiating. It is electric like in nature. It is triggered with weather changes and certain movements of her neck. It is relieved with massage and hot showers and pain medication. Previous treatments include medications, TENS unit, massage, hot and cold packs, injections, and surgery.

Dr. Reynold's assessment listed the following conditions: "Trigeminal neuralgia without any pain for the past six months," "[n]eck pain," "[p]ain over the right mastoid region, status post two trigeminal nerve decompression surgeries," "[b]ilateral knee pain," "[o]steoarthritis of multiple joints," "[c]hronic pain syndrome," and "[o]pioid dependence."

Dr. Reynolds wrote the following under the "Plan" portion of his report:

> Today, the patient reports that her pharmacy will no longer fill the large quantity of Morphine that she had been receiving. I told her that we have experience [*sic*] the same phenomenon in our patient population and with essentially all pharmacies that we come and [*sic*] contact with. I think it is reasonable to try this patient without opioid medications as she is [*sic*] not had any trigeminal pain in the past six months. I doubt that, she will be successful in tapering off the opioids. She is not interested in tapering off the opioids. I think that, she reportedly had [*sic*] better success by going to inpatient detox I talk [*sic*] to her about this once again [*sic*] she is not interested in inpatient detox, and says that she will talk to Dr. Schwartz regarding these options in the future.

28. Dr. Schwartz discussed the appointment with Dr. Reynolds with J.S. during her January 30, 2014, office visit. The medical records for that visit noted, "Pain management MD was very dismissive of her complaints and not helpful." The records reflected that J.S.'s current medication at that time was Morphine Sulfate 30 mg tablets, one tablet every three hours. Dilaudid was no longer noted as one of her medications. In addition to including the same medical problems as the records of previous visits, the January 30, 2014, office visit record included the following language under the heading "Pain Assessment":

> Patient presents today for chronic pain. The patient notes pain in the back of head. On severity scale of 1 to 10, she says it is a 5. She describes the pain as intermittent. The pain is made worse by weather changes or trigeminal neuralgia. The pain is improved by rest.

29. On February 4, 2014, Dr. Schwartz electronically signed another referral to Inland Pain Medicine, seeking a second opinion, "not Dr. Reynolds." Dr. Schwartz's referral for a second opinion was approved on March 5, 2014, for J.S. to see Dr. Cho. J.S. saw Dr. Schwartz again on March 13, 2014, and the medical record for that visit listed her chief complaint as: "Wants to speak to doctor about getting another referral." The medical record for that office visit included the following "Pain Assessment":

> The patient notes a headache. On severity scale of 1 to 10, she says it is a 3. She describes the pain as constant and aching. The pain is made worse by weather changes. The pain is improved by medication and rest.

30. On March 13, 2014, Dr. Schwartz signed another referral form, referring J.S. to see Dr. Bryan Lee for pain management. The reason given for the referral was: "Patient is requesting a different pain management site than the Pain [*sic*] management in Colton. States not a positive experience." Dr. Schwartz saw J.S. again on May 21, 2014, as a follow up to her appointment with Dr. Lee. The medical record noted: "Dr. Lee thought she refused detox, she did not want to see another Dr. in Dr. Reynolds [*sic*] office?" On May 22, 2014, Dr. Schwartz signed another referral, but did not specify a doctor or practice to which the referral was being made. The reason given for the referral was: "Patient needs addiction specialist and likely inpatient detox Real [*sic*] case management need to help." When Dr. Schwartz completed this referral, he did not know what was available and he wanted to help J.S. get off the medications.

31. Dr. Schwartz also referred J.S. to physical therapy, which she began in July 2014. A report from Rancho Physical Therapy, Inc., noted:

> [J.S.] is a 67 year-old female who reports a history of gradually increasing head and neck pain, that began around 10 years ago and was not associated with a post-operative condition. Patient

> underwent cervical and thoracic fusions (see medical hx), and developed right trigeminal neuralgia as a result. She was previously having severe, constant pain and spasms in the face and neck, however this was mostly relieved after multiple surgeries. She has been referred to therapy for treatment of her continued neck pain, as well as diminished use of her right UE.

32. During 2015, J.S. had office visits with Dr. Schwartz on January 7, 2015, April 16, 2015, July 21, 2015, November 19, 2015, and December 17, 2015. Dr. Schwartz continued to prescribe Morphine Sulfate, 30 mg, one tablet every three hours. J.S. also continued to see a physical therapist, and the April 15, 2015, office visit record indicated Dr. Schwartz referred J.S. to a rheumatologist. An August 27, 2015, Ameritox Medication Monitoring Solutions report showed that a urine drug screen was performed. Only the December 17, 2015, office visit records included a pain assessment, which stated:

> The patient notes a headache. On severity scale of 1 to 10, she says it is a 7. She described the pain as constant, throbbing, shooting and aching. The pain is made worse by weather changes. The pain is improved by medication and rest.

33. On August 21, 2015, and August 11, 2016, J.S. filled out Initial Pain Assessment forms and signed Pain Management Agreements. On the August 21, 2015, Initial Pain Assessment form, J.S. wrote that her pain problems started as follows: "Trigeminal Neuralgia – Facial seizures – 2 Brain Surgeries. Pain since 1988 when first seizure occurred." She listed different treatments and rated how effective they had been, including physical therapy; TENS implants, that had since been removed; Dilaudid; and Morphine Sulfate. She rated the Dilaudid as the most effective and the TENS implants as the least effective, followed by physical therapy, as the second least effective.

34. Dr. Schwartz presented medical records for J.S.'s office visits on January 15, March 7, April 7, May 6, June 7, July 11, September 9, and November 10, 2016, and January 9, 2017. The records for each of those office visits included a pain assessment that noted the location, severity, and description of J.S.'s pain, and the things that worsened and improved her pain.

35. According to Dr. Schwartz, J.S. was suffering from an incurable condition, and Dr. Schwartz's treatment plan was to keep her comfortable and able to function in her daily life. He considered it to be palliative care, and he believed that because all the elements of her history were noted in her chart, he did not need to document the palliative purpose.

36. According to J.S.'s declaration testimony, which was consistent with the medical records and Dr. Schwartz's testimony, J.S. has never taken more medication than prescribed, never sought similar medications from other doctors, never overdosed, never sold her medications, never shared her medications with anyone, and never used street drugs. She

does not smoke or drink alcohol, and she has always complied with Dr. Schwartz's instructions. The pain medication improved her mood, and she stated that "it allows a reasonable degree of normal functioning as a mother and a grandmother." On the videotaped interview, J.S. stated that she has never been pain free.

37. J.S. provided the following declaration testimony regarding Dr. Schwartz:

> Throughout all of the years of treatment by Dr. Schwartz, I have always appreciated his concern and his compassion for my well-being. Dr. Schwartz has always taken the time to listen to me. I have had the familiarity to compare his care with others. He made a sincere effort to educate me and to not judge as the others had. He is the most caring physician that I have come across in my life. I am grateful for his excellent service to me throughout the past eleven years.

PATIENT G.S.[7]

38. Dr. Schwartz testified about his treatment of G.S. and G.S.'s medical records were received in evidence.

39. Dr. Schwartz inherited G.S. as a patient when he purchased a medical practice, and he first saw G.S. in 1999. G.S. had a past history of heroin use, was opioid dependent, was on Methadone maintenance, and was already being treated for chronic pain before Dr. Schwartz became his physician. Dr. Schwartz could not remember during the hearing how long ago G.S. had used heroin, but he was confident that G.S. was not using illicit substances while Dr. Schwartz was treating him.

40. G.S. suffered from chronic leg and low back pain, severe swelling in his abdomen and both his legs, Hepatitis C, cirrhosis of the liver, end stage liver disease, peripheral neurotrophy, blood pressure issues, insomnia, anxiety disorder, and major depressive disorder. G.S. was not very mobile and his legs were massively swollen and inflamed. During Dr. Schwartz's treatment of G.S., G.S. was diagnosed with stage 3 laryngeal cancer. The five-year survival rate for stage 3 laryngeal cancer is approximately 36 percent. G.S. underwent some radiation therapy, but he had problems getting to his radiation appointments due to transportation issues. He was placed in hospice for a brief period of time during 2012.

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[7] The first amended accusation alleged Dr. Schwartz's treatment of G.S. from February 7, 2011, through December 10, 2012, provided cause to discipline his certificate. Consideration of G.S.'s treatment before February 7, 2011, was important to understand G.S.'s condition and the treatment he had received before the time period at issue.

41. The earliest document in the medical records submitted regarding G.S. was a pain management agreement G.S. signed on September 27, 2005. The 2005 medical records noted that G.S. was methadone dependent and suffering from chronic pain. Dr. Schwartz testified that he was always more vigilant with G.S. because of his past history using heroin.

42. In a November 1, 2005, pain assessment, G.S. described his pain as an 8 or 9. The same document asked G.S. to circle words that described his pain, and G.S. circled aching, throbbing, shooting, stabbing, gnawing, intermittent, sharp, burning, continuous, nagging, numb, and miserable. He also wrote that he needed medicine so he could sleep, and that he woke up "every hour or half."

43. In a September 24, 2007, pain assessment, G.S. wrote that he had pain "all over" his back, legs, arms, shoulders, and that it was feeling worse. He described his pain as stabbing, sharp, unbearable, and continuous. He rated his pain on a scale of 0 to 10 (with 10 meaning "[P]ain as bad as you can imagine") as between 9 and 10. He wrote that his pain was "never ending"; that with treatment (listing the medications Methadone, Valium, and Aldactone), his pain ranged between 6 and 7, on a scale of 1 to 10 (with 10 meaning complete relief); and that he needed something stronger. After that pain assessment, the medical records indicated G.S. was also prescribed Duragesic (or a Fentanyl patch).

44. In a March 10, 2010, pain assessment, G.S. rated his pain as between 3 and 8, and he signed a pain management agreement dated March 24, 1910 (which the parties agreed must have been signed in 2010). During 2010, Dr. Schwartz began prescribing G.S. Morphine Sulfate, Kadian, and Oxycodone.

45. Dr. Schwartz's office visit record dated February 2, 2011, noted that G.S. had "pain," "shoulder pain," and "anxiety." The record also noted "walks with a cane." His medications were listed as Zoloft, Duragesic, Kadian, and Valium. The March 3, 2011, office visit record noted that G.S. suffered from GERD and lower back pain. Dr. Schwartz wrote Valium, Duragesic, and Kadian prescriptions in March 2011. The March 31, 2011, office visit record noted "chronic pain," that G.S. stated the Kadian was not helping, and that they discussed changing his medication. Dr. Schwartz continued to prescribe Kadian. The April 27, 2011, office visit record noted lower back pain, leg pain, and depression.

46. At the May 4, 2011, office visit, Dr. Schwartz discussed the need for G.S. to see an ENT (ear nose and throat doctor). A record from Riverside County Regional Medical Center indicated that Dr. Schwartz had previously referred G.S. to an ENT on October 12, 2010.

47. Ryan Grover, M.D., of the Loma Linda University Medical Center, provided Dr. Schwartz a written report, dated June 20, 2011, which described Dr. Grover's initial June 2, 2011, evaluation of G.S. The report stated G.S. had "squamous cell carcinoma of the supraglottic larynx" and gave the following history of his illness:

> [G.S.] is a 52 year-old male who presented to Riverside County Regional Medical Center with several-month history of sore

throat. A flexible laryngoscopic examination was performed on 4/29/11 which revealed a mass in the supraglottic larynx . . . .

The patient subsequently received a CT scan of the neck which revealed an area of soft tissue irregularity and thickening mostly of the vocal folds with extension to the epiglottis and vallecula. No abnormal lymph nodes were noted on exam. These images were subsequently reviewed at head and neck tumor board and it appeared the lesion did invade the pre-epiglottic fat space, although this was not originally mentioned in the initial radiology report.

On 5/9/11, the patient was taken to the OR by Dr. Charles Stewart IV who performed a microlaryngoscopy with esophagoscopy. Intraoperatively, the patient was noted to have a large tumor appearing to extend from the laryngeal surface of the epiglottis and involving the petiole and the anterior commissure as well as extending onto the right and left false vocal folds. A debulking/biopsy was performed at this time. Given the extent of disease and concern for airway compromise, a tracheostomy was also performed. Of note, examination of the cervical esophagus was negative.

Pathological examination of the biopsy specimen revealed a moderate to poorly squamous cell carcinoma.

Following his surgery, the patient met with Dr. Stewart to discuss his treatment options. The patient was offered surgical resection; however, he was very interested in organ preservation approaches, and hence is referred her [*sic*] today for that discussion.

Dr. Grover recommended that G.S. undergo a definitive "chemoradiation with standard fractionated radiotherapy," and G.S. agreed to proceed with the recommended therapy.

48. On June 27, 2011, Dr. Schwartz wrote a letter to MediCal regarding G.S., in which he stated:

I can verify that this patient has been diagnosed with Laryngeal cancer. His is currently undergoing radiation therapy. This patient has already been opiate dependent for several years due to his longstanding orthopedic disabilities; therefore, his narcotic requirements are large. He was previously controlled on Kadian 100mg 3 tablets four times daily. He requested an

> increase to 4 tablets four times daily and this was denied because Kadian was long-acting preparation. I have switched this to shorter acting Morphine 100mg 4tablets [*sic*] at this time. In addition to Morphine, this patient is on a 100mcg Fentanyl patch.
>
> Please expedite the request for this patient's narcotic needs as he is suffering immensely.

49. On July 6, 2011, Dr. Schwartz discussed G.S.'s medications with him and the problems G.S. was having getting his prescriptions filled. G.S. was informed that he needed to choose one pharmacy, he would need to be the only person who picked up his prescriptions, and Dr. Schwartz could not keep giving him random prescriptions. G.S. chose a specific pharmacy. Also on July 6, 2011, Dr. Schwartz completed an IEHP Pharmacy Exception Request (PER) Form, listing G.S.'s diagnosis as laryngeal cancer and his medications as Morphine 100 mg and Fentanyl patch, indicating G.S.'s pain was a 10 on a scale of 1 to 10, and noting that someone had picked up G.S.'s prescription from the pharmacy, which the patient had denied knowing about. Dr. Schwartz also wrote on the form that: "This patient has longstanding opiate dependence due to orthopedic condition. Now undergoing chemo & radiation for cancer."

50. Dr. Grover's clinical September 13, 2011, end of treatment report noted that G.S. had missed several appointments due to transportation and personal issues and was counseled about the importance of compliance with treatment. G.S. was not able to see the oncologists prior to or during radiotherapy, and they elected to initiate radiotherapy without chemotherapy in order to avoid further treatment delays.

In a later, October 26, 2011, report, regarding a follow up office visit, Dr. Grover, noted that G.S. was scheduled to receive his first chemotherapy treatment on November 9, 2011. During the October 26, 2011, visit, G.S. complained to Dr. Grover about pain at his tracheostomy site, which had since been closed. G.S. described it as a pulling sensation, making it difficult for him to hyperextend his chin. The October 26, 2011, report also stated:

> He has had some difficulty having pain medications refilled; from his description this seems to be due to having difficulty making his appointments. He does have a primary care physician who has been following him and managing his pain. He recently presented to urgent care, however, with pain, having run out of his supply of fentanyl patches and he apparently received a prescription for Valium at that time and was planning to call his primary care physician to discuss continuation of the fentanyl patch. Pain is primarily centered in the throat, although he does have some shoulder pain as well, and he also reports some pain in the back of the head and neck which does wake him up at night.

51. G.S. asked to be placed in hospice in January 2012, and notes in his medical records indicated he was placed in hospice on January 25, 2012, and that the "hospice doctor" changed his Methadone dosage on January 31, 2012. Other records indicated that G.S. was being discharged from Hospice in February 2012, but he wanted to return. Dr. Schwartz signed Hospice Certification of Terminal Illness forms on February 28, 2012, and March 7, 2012.

52. Dr. Schwartz completed an IEHP Pain Assessment & Treatment form in September 2012, in which he noted G.S.'s pain was 10 on a scale from 0 to 10. Dr. Schwartz listed the following medications: Dilaudid 4 mg, Norco 10/325, and Oxycontin 80 mg, and noted that G.S. would be needing Oxycontin on a monthly basis. Dr. Schwartz prepared another IEHP Pharmacy Exception Request (PER) Form in October 2012, this time noting G.S.'s pain was a 9 on a scale from 0 to 10. The medications listed were Norco 10/325, Oxycontin 80 mg, and Dilaudid 4 mg. On the form, Dr. Schwartz noted that "patient will need this regimen on a monthly basis." On December 3, 2012, Dr. Schwartz completed another IEHP Pain Assessment & Treatment form, and noted G.S.'s pain was a 10 on a scale of 0 to 10. The medications listed were Norco 10/325, Oxycontin 80 mg, Duragesic 50 mcg, and Duragesic 100 mcg. Dr. Schwartz also noted, "[a]djusted dose due to increased pain."

53. In addition to the records described above, during 2011 and 2012, which is the relevant time period based on the allegations in the first amended accusation, there were office visit notes in the medical records dated January 13, 2011; January 24, 2011; February 2, 2011; March 3, 2011; March 31, 2011; April 27, 2011; May 4, 2011; May 10, 2011; June 1, 2011; June 16, 2011; June 27, 2011; June 29, 2011; June 27, 2011; August 10, 2011; September 15, 2011; October 19, 2011; October 27, 2011; November 10, 2011; December 7, 2011; December 19, 2011; December 28, 2011; January 11, 2012; May 2, 2012; June 22, 2012; July 11, 2012; July 18, 2012; August 6, 2012; August 27, 2012; September 5, 2012; September 19, 2012; October 3, 2012; November 7, 2012; December 2, 2012; and December 17, 2012. The office visit notes for June 1, 2011; August 10, 2011; October 19, 2011; December 7, 2011; and December 11, 2011, indicated that G.S. missed those appointments.

The office visit records for the 2011 calendar year through January 11, 2012, were handwritten, difficult to read, and did not have detailed information about G.S.'s pain, although they did mention his back pain, swollen legs, and cancer. The 2012 office visit records were electronic, much easier to read, and contained considerable detail. The electronic 2012 office visit records did not have a "Pain Assessment" heading or any detailed assessment of G.S.'s pain similar to what Dr. Schwartz wrote in the IEHP pain assessments and pharmacy exception forms noted above, which were also part of Dr. Schwartz's medical records for treatment of G.S. However, the office visit records did note complaints of pain, including: "joint pain, muscle weakness, stiffness" on May 2, 2012; "pain is worse" on July 11, 2012; "pain on neck shoulder and back" on August 27, 2012; G.S. stated Oxycontin 80 mg "helped" and he "would like rx because present meds do not help" on September 5, 2012; and G.S. "complains of muscle cramps, joint pain, joint swelling, back pain, stiffness, arteritis, and muscle aches" on December 17, 2012.

The 2011 and 2012 records also included Medical Refill Visit Note forms that were completed on March 23, 2011, and July 27, 2011. The preprinted forms included questions regarding whether the pain was controlled on the current regimen; and spaces to note the patient's explanation and the length of time of efficacy; whether the patient used the same pharmacy and the name and number of the pharmacy; whether the patient was receiving medications from another health care provider; the last date the patient saw Dr. Schwartz; whether the patient had a pain contract with the doctor; and current medications. Blank Medical Refill Visit Note forms were also in the file, some with notes indicating that the appointments were cancelled or G.S. failed to show up on September 26, 2011; October 26, 2011; November 23, 2011; December 21, 2011; January 18, 2012; February 22, 2012; and March 28, 2012.

54. An IEHP Member History, printed November 20, 2012, was in G.S.'s medical records, listing details regarding prescriptions filled from November 23, 2011, through November 7, 2012, including the pharmacy, medication, quantity, date filled, and prescriber. Another IEHP Member History, printed June 14, 2013, included details about prescriptions filled after November 20, 2012, through the end of 2012. These records showed that the following medications Dr. Schwartz prescribed that at issue in this matter were dispensed to G.S. on the following dates:[8]

Morphine 100 mg (Kadian)	300	November 23, 2011
	720	December 14, 2011
	720	January 11, 2012
Fentanyl 100 mcg patch (Duragesic)	10	December 14, 2011
	10	January 11, 2011
	10	April 27, 2012
	10	June 22, 2012
	10	August 6, 2012
	10	November 2, 2012
Fentanyl 25 mcg patch (Duragesic)	10	December 14, 2011
	10	January 11, 2012
Fentanyl 50 mcg patch (Duragesic)	10	April 27, 2012
	10	June 22, 2012
	10	August 6, 2012
	10	November 2, 2012

[8] In light of difficulties G.S. had getting his prescriptions filled, the written prescriptions (which sometimes needed to be re-written) were not reliable records of the medications actually dispensed to G.S. The IEHP member histories provided information regarding the medications G.S. actually received from the pharmacy.

Diazepam 10 mg	120	January 11, 2012
Hydrocodone-Acetaminophen (Norco)	180	May 2, 2012
	90	June 1, 2012
	120	June 22, 2012
	360	July 18, 2012
	240	August 29, 2012
	240	September 28, 2012
	240	October 27, 2012
	240	November 20, 2012
	360	December 10, 2012
Lorazepam 1 mg (Ativan)	120	May 8, 2012
	90	June 25, 2012
Hydromorphone 4 mg (Dilaudid)	360	May 19, 2012
	120	July 24, 2012
	120	August 27, 2012
Hydromorphone 2 mg (Dilaudid)	120	June 26, 2012
Zolpidem 10 mg (Ambien)	30	June 25, 2012
	60	July 7, 2012
	30	August 4, 2012
	60	August 21, 2012
	30	September 19, 2012
	30	October 17, 2012
	60	November 7, 2012
	60	December 13, 2012
Alprazolam 2 mg (Xanax)	90	July 11, 2012
	90	August 8. 2012
	90	September 3, 2012
	90	October 3, 2012
	90	November 2, 2012
	90	November 29, 2012
	90	December 25, 2012
Oxycontin 80 mg	90	September 19, 2012
	90	October 17, 2012
	120	November 19, 2012
	120	December 17, 2012

55. Dr. Schwartz explained that he prescribed Valium to help G.S. with anxiety and muscle spasms. Dr. Schwartz later prescribed Ativan in lieu of Valium, and when the Ativan was not helping, he prescribed Xanax for G.S.'s anxiety. Dilaudid was prescribed to alleviate G.S.'s cancer pain; Norco was prescribed for breakthrough pain; and Oxycontin was also prescribed for pain.

56. Although G.S. suffered from back pain, Dr. Schwartz did not refer him to an orthopedic specialist because there was no point while G.S. was dealing with his cancer. Additionally, previous x-rays had shown no significant abnormalities, and with G.S.'s history with Hepatitis C, no surgical option would have been considered.

57. Dr. Schwartz continued to treat G.S. after December 10, 2012, the end of the time period when the first amended accusation alleged Dr. Schwartz engaged in negligence and/or unprofessional conduct in his treatment and care of G.S. Beginning in October 2013, most of Dr. Schwartz's office visit notes contained "pain assessments," which noted the location, severity, and description of G.S.'s pain; activities that worsened the pain; and any treatments that improved the pain. G.S. passed away in 2015 from a cardiac event, and his cancer was a contributory cause of his death.

PATIENT E.G.[9]

58. Dr. Schwartz and E.G. testified about E.G.'s medical treatment, and E.G.'s medical records were received in evidence. A video recording of an interview of E.G. was also considered.[10]

59. Patient E.G. is a 56-year-old woman who resides in Beaumont, California. She began seeing Dr. Schwartz on January 12, 2011, after her insurance changed and she could no longer go to Kaiser Permanente. Before seeing Dr. Schwartz, she suffered from Lupus; Rheumatoid Arthritis; Fibromyalgia; "very bad nerve damage" to her elbows, knees, and wrists; lumbago; and she was opioid dependent. She had already undergone surgeries to her joints and blood transfusions. Before seeing Dr. Schwartz, E.G. was taking pain medications, including Hydrocodone and Prednisone.

60. On an undated medical history form in E.G.'s medical records, under the heading "Past Medical History," boxes were checked for anxiety, autoimmune disorder,

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[9] The first amended accusation alleged Dr. Schwartz's treatment of E.G. from January 12, 2011, through December 22, 2013, provided cause to discipline his certificate. Consideration of E.G.'s treatment before January 12, 2011, was important to understand E.G.'s condition and the treatment she had received before the time period at issue.

[10] E.G.'s videotaped interview was received in evidence as administrative hearsay and was considered to the extent it supplemented and explained other admissible evidence. (Gov. Code, § 11513, subd. (d).)

blood transfusions, depression, and rheumatoid arthritis. At her initial visit with Dr. Schwartz on January 12, 2011, E.G. complained of being unable to extend her right hand, with pain of 4 on a scale from 1 to 10. Dr. Schwartz then referred E.G. to a rheumatologist and prescribed her with Norco 10/325, Oxycontin 80 mg, and Adderall.

61. The rheumatologist, Babak Zamiri, M.D., F.A.C.P., F.A.C.R., sent Dr. Schwartz a written report after Dr. Zamiri's February 7, 2011, initial consultation. That report described E.G.'s history of present illness as follows:

> This is a 49-year-old-female with a past medical history of rheumatoid arthritis, depression, Crohns [*sic*] disease, osteoarthritis, and GERD who was kindly referred by Dr. Schwartz for further evaluation. She was diagnosed with rheumatoid arthritis twenty-five years ago during pregnancy. The pain started in elbows and knees. Twelve years ago she saw a rheumatologist at Kaiser and he confirmed the diagnosis of rheumatoid arthritis and fibromyalgia and she received Plaquenil, which did not work, then methotrexate eight tablets a week which she was not taking regularly. She then took sulfasalazine and Arava which did not work. Then she was started on Humira and responded very well. Then she lost Kaiser six years ago and stopped the Humira and has not seen a rheumatologist since. Her prior primary care physician was giving her methotrexate and prednisone. She currently takes Norco 10/325 mg every four hours plus Ultram and uses a cane. In April she lost range of motion of the right arm and had to have surgery. She has constant dry eyes, dry mouth, hair loss, rash, photosensitivity, Raynaud, mouth sores, and joint swelling. She has depression, anxiety, stress, interrupted sleep, fatigue, memory loss, mood swings, and severe headaches.

Dr. Zamiri's report also stated that E.G. suffered from back pain and noted her past surgical history of bilateral knee and elbow surgery and wrist extensor tendon surgery. In his recommendations, Dr. Zamiri stressed that "[w]ith her severe rheumatoid arthritis, we need to be very aggressive on her management, with a combination of medications and possibly using TNF alpha-blockers. I will start her on proper medication when I see her next visit."

62. During 2011, Dr. Schwartz tried Butrans in an effort to reduce E.G.'s acetaminophen intake to protect E.G.'s liver. But Butrans was not successful. He was able to reduce the acetaminophen she consumed from 6 mg to 4 mg when he switched her to Norco. He was trying to keep her comfortable and control her pain, while at the same time reducing the impact of the medications on her liver.

63. On March 30, 2011, E.G. saw Dr. Schwartz for a refill of her medications, and he then noted that she was "having a bad flare up." His records indicated that he performed

an examination, but the records did not contain a pain assessment. The portions of the form regarding pain severity were left blank. Dr. Schwartz continued to refill E.G.'s prescriptions for Oxycontin, Norco, and Adderall through 2011, and he prescribed Xanax in August 2011.

64. On February 1, 2012, Dr. Schwartz completed an Inland Empire Health Plan (IEHP) Pain Assessment and Treatment Plan, listing E.G.'s conditions as "SLE, Lupus," and noting her pain as 9 on a scale of 1 to 10; her pain scale goal as 6 on a scale of 1 to 10, and stating that she had not experienced side effects from her current medication and she was not exhibiting any potential aberrant drug related behavior. He wrote that her current medication regimen was Oxycontin, 80 mg, one tablet every four hours; Norco 10/325, two tablets every four hours; Adderall 5 mg, twice a day; and Sabella 50 mg, four times a day.

65. On August 27, 2012, Dr. Schwartz signed an IEHP Pain Assessment and Treatment Plan, stating that E.G.'s pain was 10 on a scale from 1 to 10, her pain goal was 8 on a scale of 1 to 10, and she had no side effects or aberrant drug related behavior. He listed her current regimen as Oxycontin 80 mg, one tablet every eight hours; Norco 10/325, two tablets every four hours; Xanax 2 mg, twice a day; and Adderall 5 mg, twice a day. She was also taking Ambien once a day. She remained on those medications through July 2015.

66. Dr. Schwartz's electronic records of E.G.'s office visits through August 21, 2013, did not contain a heading for "Pain Assessment." However, on the records for the July 8, 2013, office visit, it stated that her chief complaint was "[s]evere back pain, unable to sit and barely walk," and that she was "[c]omplaining of back pain after twisting." That record also noted that it "[s]ounds like muscle spasm causing her to fall." On August 21, 2013, E.G. presented with "left leg swelling with bruising . . . unable to walk-painful." On November 6, 2013, during E.G.'s office visit, she complained of "right flank pain that spreads to the back." There was a pain assessment noted for that visit that stated: "Right flank pain. She also presents today for follow-up assessment. She describes the pain as burning. The pain is made worse by sitting. The pain is improved by medication."

67. According to E.G., before she was seeing Dr. Schwartz, she could not even get out of bed. He has changed her life and given her a better quality of life by helping her with her pain. Dr. Schwartz explained to E.G. the effects the pain medications could have on her organs, and she decided to assume those risks. She described her pain as "like electricity." Dr. Schwartz also helped her with her insomnia. She has signed a pain contract, which she tries to abide by. She has never taken drugs she was not prescribed, never given her medications to others, and never overdosed. She wanted to testify because without Dr. Schwartz she would not be able to get up and do things. She did not know what she would do without him. On the videotaped interview, G.S. stated that she has never been pain free.

68. Dr. Schwartz considered his care of E.G. to be palliative in order to relieve her symptoms of fatigue, anxiety, and pain. He prescribed Xanax to treat her severe anxiety, which was related to her chronic conditions. He prescribed Adderall to help with her cognitive functioning and fatigue. And he prescribed Ambien to treat her fragmented sleep insomnia.

69. Although E.G.'s medical records were received in evidence for time periods after December 22, 2013, complainant did not allege any negligence or unprofessional conduct with respect to Dr. Schwartz's treatment of E.G. on any date after December 22, 2013. E.G. did not sign a pain contract until 2015 and 2016, which was also after the time frame alleged in the first amended accusation.[11]

Complainant's Expert Witness

70. Nehal G. Patel, M.D., C.M.D., was the medical expert who reviewed Dr. Schwartz's medical records and subject interview before complainant decided to pursue this disciplinary action. Dr. Patel prepared two written reports, both dated December 30, 2016, one of which he signed, and he testified at the hearing.

71. Dr. Patel has practiced medicine for approximately 15 years, having received his California certificate in 2001. He currently holds board certifications in hospice and palliative care. He is not board certified in pain management, and he is not currently board certified in family practice, as he needs to retake the examination. He has been an expert evaluator for the board for the past three years.

72. Dr. Patel obtained his Bachelor of Arts Degree in Psychology from the University of California, Riverside in 1994. He obtained his Master of Science Degree in Biomedical Sciences in 1996, and his Doctorate in Medicine in 1998, both from the American University of the Caribbean School of Medicine. He did his internship (1999-2000) and residency (2000-2002) at King/Drew Medical Center, Department of Family Medicine. In 2003, he completed a fellowship in geriatric medicine at University of California Los Angeles-Veterans Administration Medical Centers.

According to Dr. Patel's curriculum vitae, he worked as an attending physician for West Los Angeles Veterans Administration Medical Center from July 2003 to June 2004; an attending physician in geriatrics, hospice/palliative medicine, for Inpatient Consult and Family Attending, Inland Nursing Home & Alzheimer's Unit from February 2004 to the present; An MDSI, Physician Disability Examiner, in various locations in Southern California, from July 2004 until the present; Assistant Clinical Dean, at West Coast, American University of the Caribbean School of Medicine from May 2005 to the present; a physician (he did not provide a title) at Metro State Hospital, Family Medicine and Geriatric Medicine from October 2006 to the present; an expert medical reviewer for the board from July 2006 through July 2011; and a district medical consultant for the board from August 2011 through August 2013. As a district medical consultant, Dr. Patel worked in a local

[11] Complainant's counsel spent a great deal of time questioning E.G., Dr. Schwartz, and both parties' expert witnesses about E.G.'s 2015 and 2016 pain assessments and pain contracts, which seemed to be identical except for the dates, even though the first amended accusation did not allege Dr. Schwartz engaged in any negligence in his treatment and care of E.G. after December 22, 2013.

board office reviewing initial complaints and recommending whether matters should be sent out for expert medical review. Dr. Patel's Curriculum Vitae is not up to date and does not include his correct business address.

73. Dr. Patel described his practice as including geriatric medicine, hospice, palliative care, and pain management, treating patients receiving outpatient care, care in skilled nursing homes, and in-home care. He has approximately 2,500 patients. He does not have his own private practice. He works in various facilities and conducts home visits. He estimated that 50 percent of his practice is devoted to geriatric care; 20 percent is home health, home hospice, and palliative care; and 30 percent is pain management. Dr. Patel has been practicing pain management for approximately 10 years, including treating patients in hospice care.

74. Dr. Patel stated that palliative care means care to prevent and relieve pain from "life limiting" illnesses. The illnesses being treated need not be "life threatening," and palliative care may not always be a stepping stone to hospice care.

75. In 2016, the board asked Dr. Patel to review documents and write a report regarding Dr. Schwartz's practice. On December 30, 2016, Dr. Patel provided board investigator Larry Bennet two written reports, first a seven-page unsigned report, and then an eight-page signed report. At the time Dr. Patel wrote the two versions of his report, he understood that they could be used to form the basis for an accusation against Dr. Schwartz. He acknowledged during the instant hearing that it was important that the facts he relied upon were accurate and that he was fair and objective to Dr. Schwartz.

DR. PATEL'S EXPLANATION OF THE STANDARD OF CARE IN HIS DECEMBER 30, 2016, WRITTEN REPORT

76. In his signed report, Dr. Patel outlined the "standard of care" he applied when evaluating Dr. Schwartz's care of each of the three patients as follows:

> **a. Standard of Care**
>
> i. The California Medical Board (CMB) has outlined a list of guidelines physicians should follow "Guidelines for Prescribing Controlled Substances for Pain."
>
> ii. In 1994, revised in 2007 and 2014, the California Medical Board adopted a formal policy statement titled "Prescribing Controlled Substances" in an effort to guide physician treatment of chronic pain patients while preventing drug diversion and abuse. This statement gives a general framework for physicians

to follow, and requires[12] that the physician perform the following data gathering steps both at the initial encounter and at follow-up visits:

1. Federal law [*sic*][13]

2. A thorough medical history and physical examination, including substance abuse history, psychological function, prior pain treatments, assessment of coexisting conditions and diseases, and documentation of the presence of a recognized medical indication for the use of controlled substances.

3. A treatment plan and objectives for said treatment plan. The treatment plan should state objectives for pain relief and methods by which the treatment plan can be evaluated. The pharmacological treatment plan should be tailored to each individual patient and used in conjunction with other treatment modalities, such as physical and occupational therapy.

4. Informed consent should be attained from all chronic pain patients, which [*sic*] a discussion regarding the potential adverse reactions, risks, and benefits of all pharmacological therapy (not required).[14]

5. A periodic review by the physician should be conducted aimed at determining progress towards the original treatment plan and objectives. Continuation or modifications of controlled substances should be made based on these findings.

6. The physician should consider consultation with other practitioners in an effort to reach the treatment plan and objectives is [*sic*] progress is not being made.

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[12] As is discussed further below, the board's guidelines for prescribing controlled substances are not requirements and do not set the standard of care.

[13] Because there was no punctuation after the word "law," it was unclear whether something may have been missing from this portion of Dr. Patel's report. Dr. Patel did not elaborate on this "step" in his report or during his testimony.

[14] Dr. Patel did not explain why he listed this item as being required by the "standard of care" when he also characterized it as "not required."

7. The physician should keep accurate and complete records in regards to the above items, with documented medical history and physical examination, treatment plan and objectives, informed consent, treatments for other medical conditions, concurrent medications, periodic reviews of the treatment plan, agreements with the patient, and any consultations with other physicians. In addition, periodic reviews should be conducted at least annually. Pain levels, level of function, and overall quality of life should be documented in both a subjective, patient described manner and an objective, physician-finding manner.

8. Federal law dictates how prescriptions for controlled substances should be written. DEA regulations 21 CFR 1306.05 state [*sic*]: "Manner of issuance of prescriptions: (a) All prescriptions for controlled substances shall be dated as of, and signed on, the day when issued and shall bear the full name and address of the patient, the drug name, strength, dosage form, quantity prescribed, directions for use, and the name, address, and registration number of the practitioner. A practitioner may sign a prescription in the same manner as he would sign a check or legal document."

DR. PATEL'S TESTIMONY REGARDING THE APPLICABLE STANDARD OF CARE

77. Dr. Patel explained that the standard of care he applied when conducting his evaluation was based on the what was commonly accepted at the time of his review. He defined a simple departure from the standard to mean a "negligent act," and an extreme department to mean "gross negligence." He stated that not performing tests or not referring a patient to a specialist were examples of gross negligence. When discussing the standard of care, Dr. Patel referred to the board's "*Guidelines for Prescribing Controlled Substances for Pain*," which he testified were first published in 1994, and later revised in 2007 and 2014, and he stated that the "standard of care has been the same since 1994," but there is now "more scrutiny" regarding documentation and referrals to pain specialists. Dr. Patel also stated that nothing in the *Prescribing Guidelines* mandated referral to a pain specialist, so failure to do so "in itself" would not be a departure from the standard of care. This seemed to contradicted his testimony that failure to refer a patient to a specialist was an example of gross negligence.

78. According to Dr. Patel, during the timeframe from 2010 through 2015, a physician should do the following at the first visit with a patient being treated for severe pain: (1) obtain vitals; (2) obtain a full history, including family and social history; (3) conduct a complete physician examination; (4) conduct a detailed physical examination of the body part at issue; (5) review labs, tests, and x-rays; (6) possibly conduct a drug screen; (7) review other prior treatment; (8) review medication history, including a review of the CURES report; and (9) conduct a comprehensive assessment and treatment plan.

79. Dr. Patel stated that it is important to monitor aberrant drug use of all patients because many patients engage in "doctor shopping." While Dr. Patel acknowledged that reviewing CURES was not "required" until 2017, he stated that even before then it was a "prudent practice" to review CURES.

80. Pain assessments should include both objective and subjective evaluations. Dr. Patel described assessing pain using the acronym "PQRST," which he explained stood for pain, quality, radiation, severity, and time. According to Dr. Patel, a pain assessment should be conducted and documented at every visit. Later, when he was asked if the standard of care required that a pain assessment be conducted at every visit, he responded, "I do." He later seemed to indicate that a comprehensive pain assessment should be conducted annually.

81. If high doses of pain medications are being prescribed, Dr. Patel opined that the physician should see the patient every 30 days and sometimes more often. Since 2017, only a 30-day supply of pain medications may be prescribed at a time. According to Dr. Patel, during the time from 2010 through 2015, it was a common practice to prescribe up to three months of medication or more depending on the physician's discretion. In Dr. Patel's opinion, when pain medication changes, a pain assessment "should" be done, but he later stated it was not required by the standard of care.

82. Dr. Patel noted that the opioid epidemic is a national crisis, with many patients who are addicted to opioids. As a result, caring for pain management patients may be difficult, and documentation and referrals "are key." Treating chronic pain and providing palliative care are different. Patients suffering from chronic pain may become opioid dependent and seek higher doses to alleviate the pain, and many may turn to street drugs. Palliative care is focused on quality of life and pain relief as priorities of treatment. According to Dr. Patel, if a physician is providing palliative care, the palliative purpose should be specifically noted in the patient's records, and the transition to palliative care should be discussed with the patient and the patient's family and documented.

83. According to Dr. Patel, it was "within" the standard of care to have patients sign pain contracts, but he later acknowledged that pain contracts were not required by the standard of care, although they were "advisable." After he had stressed that Dr. Schwartz did not require patients to return their unused medication to be counted, Dr. Patel admitted that it was not beneath the standard of care for doctors to not count unused pills, although he thought "it would be nice." He also stated that the standard of care did not require that patients return unused pills, and the standard of care did not require drug screens.

DR. PATEL'S OPINIONS REGARDING PATIENT J.S.

84. With regard to Dr. Schwartz's treatment of patient J.S., Dr. Patel concluded in his written report that "[t]here was an **extreme departure** from the standard of care for failure to follow the guidelines for Prescribing Controlled Substances as set forth by the CMB and a **lack of knowledge.**" (Emphasis in original.) In reaching that conclusion, Dr.

Patel's report noted that "Dr. Schwartz's practice of pan [*sic*] management consists of 5-10% of his practice and this patient was on very high doses of pain medications and prescribed numerous pills each time. This patient was not receiving palliative care or hospice care (as described by CMS' Conditions of Participation)."

Dr. Patel's written analysis regarding patient J.S. did not describe J.S.'s medical conditions or treatment history. Instead, his "Analysis" read as follows:

> **b. Analysis**
>
> i. In reviewing the full medical records with regards to this patient, it does not appear that any of the available options as set forth by the CMB regarding pain management/referrals/documentation/documenting diversion/utilizing CURES consistently/specialist consultations were followed by Dr. Schwartz.
>
> ii. Although [J.S.] was referred to a pain management specialist, none of the recommendations were followed by Dr. Schwartz, most importantly the recommendation to reduce [J.S.'s] dose of Dilaudid. Furthermore, referral to a pain management specialist indicated that Dr. Schwartz was seeking the expert opinion/recommendations [*sic*] "more qualified" than him. If a referring physician does not chose [*sic*] to implement the specialist's recommendation there is little to no point of making that referral in the first place and opens up the provider to medical-legal risk. [J.S.], too, refused to agree to the pain specialist's recommendations. Dr. Schwartz should have considered discharging [J.S.] from his practice or obtaining another pain management referral or possibly considered a referral to an interventional pain management physician. Alternative treatment modalities include nerve blocks, nerve restrictions for intractable pain, internal pain pumps and more. In my professional opinion, this constitutes neglect by not following a specialist's recommendations. It would have been better to not have requested the consultation to begin with. Interventional pain management should be considered on every patient in a pain management practice.

iii. [J.S.] remained on a very high dose of oral Dilaudid,[15] receiving the same dose for an extended period of time in high quantities.[16]

85. During the hearing, Dr. Patel acknowledged that even before J.S. sought medical treatment from Dr. Schwartz, she suffered from severe pain from trigeminal neuralgia, which he described as a debilitating illness of the trigeminal nerve, which is in the facial area, that can cause severe pain. Dr. Patel testified that the sequala (or after effect of the disease) and the pain may cause a patient to develop psychological issues that could lead to death. Dr. Patel acknowledged that before 2010, J.S. had been prescribed a variety of different medications for her pain, including Percocet, Vicodin, morphine extended release, and a Fentanyl patch, and J.S. had undergone a surgical procedure to implant a device to alleviate her pain, which intervention was not successful.

86. During the timeframe from 2010 through 2015,[17] Dr. Patel was critical of Dr. Schwartz's treatment of J.S. in the following respects: There were no pain assessments until after Dr. Schwartz changed to electronic medical record keeping, and then Dr. Patel criticized the frequency of the pain assessments; there were no specialist referrals other than to Dr. Reynolds; Dr. Schwartz failed to follow Dr. Reynolds's recommendation to stop or taper off opioids; no alternate therapies were recommended; there were no pain contracts until 2015; possible early refills "concerned him"; and there were no drug screens until August 2015.

87. Dr. Patel testified that pain assessments that were contained in Dr. Schwartz's records of his treatment of J.S. beginning January 30, 2014, did comport with the standard of care. However, Dr. Patel opined that Dr. Schwartz departed from the standard of care because an extended period of time passed without an examination, pain assessment, or lab work. Dr. Patel was also critical of the records because they failed to explain why MS Contin (an extended release form of morphine sulfate) was added.

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[15] This is not accurate, as the medical records showed that J.S.'s medication was changed from Dilaudid to Morphine Sulfate in January 2014.

[16] Paragraphs (b)(ii) and (b)(iii) did not appear in the unsigned version of Dr. Patel's report.

[17] Complainant's counsel spent an inordinate amount of time asking Dr. Patel questions about the adequacy of Dr. Schwartz's documentation of pain assessments and prescriptions to this patient during the time from 2006 through 2009. While testimony regarding the different treatments attempted before 2010 was relevant to show the patient's condition before 2010, Dr. Patel's opinions regarding whether Dr. Schwartz's pre-2010 treatment departed from the standard of care was not considered in rendering this decision because the accusation was not filed until January 2017, over seven years before 2009. (Bus. & Prof. Code, § 2230.5, subd. (a).)

88. In Dr. Patel's opinion, Dr. Schwartz engaged in an extreme departure from the standard of care because he issued multiple prescriptions in excessive amounts over several months and/or years with little to no documentation and without a pain contract. If J.S. was receiving palliative care, Dr. Patel would have expected to see a detailed discussion in the medical records regarding quality versus quantity of life and an effort to rule out psychiatric illness. Because Dr. Patel did not see that in the records, he stated there was no evidence of palliative care.

DR. PATEL'S OPINIONS REGARDING PATIENT G.S.

89. With regard to Dr. Schwartz's treatment of G.S., Dr. Patel's written report stated "[t]here was a [*sic*] **extreme departure** from the standard of care for failure to follow the guidelines for Prescribing Controlled Substances as set forth by the CMB and a **lack of knowledge.**" (Emphasis in original.) Dr. Patel also wrote in the "Conclusion" portion of his report:

> i. . . . Dr. Schwartz's practice of pan [*sic*] management consists of 5-10% of his practice and this patient was on very high doses of pain medications and prescribed numerous pills each time. This patient was not receiving palliative care or hospice care (as described by CMS' Conditions of Participation).
>
> ii. G.S. was on high doses of morphine, methadone, Norco, oxycodone and Fentanyl the last several years and has not been seen/evaluated by any other physician specialists (pain management, orthopedics, or neurological/neurosurgery).

Dr. Patel's written analysis regarding patient G.S. did not describe G.S.'s medical conditions, other than mentioning that he had a "history of heroin addiction" and that he passed away in 2015 from "cardiac problems." Dr. Patel's "Analysis" read as follows:

> **b. Analysis**
>
> i. In reviewing the full medical records with regards to this patient, it does not appear that any of the available options as set forth by the CMB regarding pain management/referrals/documentation/documenting diversion/utilizing CURES consistently/specialist consultations were followed by Dr. Schwartz.
>
> ii. He inherited this patient and this patient had a history of heroin addiction. Subsequently, G.S. died in 2015 from cardiac problems. It may be probable that G.S.'s history of heroin

addiction along with multiple narcotics may have played a role in his passing.[18]

iii. Interventional pain management should be considered on every patient in a pain management practice.
iv. Dr. Schwartz admitted on the audio interview he would not have treated G.S. had he known about his heroin addiction.[19] This is a very important piece of obtaining a thorough history in all patient encounters, especially in pain management. A current or past history of drug use/abuse is a red flag when seeking narcotics for pain management.

v. Furthermore, a patient with a history of drug use/abuse is at a high risk of cardiac events (such as what occurred to G.S.) when prescribed narcotics as this can have a negative affect [*sic*] on the cardiovascular system (such as heart attack, stroke, dysrhythmias). We hear in the news about celebrity deaths associated with a history of drug use/abuse and concurrent narcotic use.[20] [21]

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[18] This statement was inflammatory and wholly irresponsible, particularly given the multiple serious and painful medical issues G.S. was facing that Dr. Patel chose not to mention in his report.

[19] This assertion was completely inaccurate. When Dr. Patel was confronted with portions of Dr. Schwartz's subject interview transcript during the instant hearing, which contradicted what Dr. Patel stated in his report and during his testimony, Dr. Patel acknowledged that Dr. Schwartz was aware of G.S.'s prior history of heroin use when Dr. Schwartz inherited him as a patient.

[20] It was very misleading to compare this matter to celebrity drug abuse cases, particularly without any analysis of the serious and painful medical issues Dr. Schwartz was treating. Dr. Patel was not acting as a dispassionate, objective, neutral reviewer when he made such inflammatory and unnecessary comments in his report. (See the board's Medical Reviewer Guidelines (revised January 2013), which states: "The expert reviewer plays a crucial part in the investigation by providing an objective, reasoned, and impartial evaluation of the case. **They are neither an advocate for the Board nor an advocate for the physician. Rather, the review is concerned primarily with whether there is a departure from the accepted standard of practice.**" (Emphasis in original.))

[21] Paragraphs (b)(iii), (b)(iv), and (b)(v) did not appear in the unsigned version of Dr. Patel's report.

90. During his hearing testimony Dr. Patel's offered critiques of Dr. Schwartz's treatment of G.S. before February 2011, and after December 2012.[22] Those criticisms were not considered in reaching the decision in this matter, as the first amended accusation only alleged Dr. Schwartz engaged in negligence with respect to his care and treatment of G.S. from February 7, 2011, through December 10, 2012.

91. Dr. Patel testified that Dr. Schwartz's treatment of G.S. fell below the standard of care because there was a lack of documentation; a lack of examinations; a lack of justification for the medication changes that were made; there was no pain contract; and there were no urine drug screens. He opined there was an extreme departure from the standard of care for the following reasons: There was a "lack of documentation regarding pain management"; "certain things need to be in each and every visit"; "multiple things" were missing; there is an "opioid crisis"; the patient was addicted to narcotics and was a prior heroin user; it would have been prudent to review the medications and a pharmacy review would have been useful; and there was no definitive pain management plan. Dr. Patel was also critical of a prescription for morphine, dated July 27, 2011, with the note "please release on 8/6/11." He stated that was not allowed under Drug Enforcement Agency (DEA) regulations.

92. On cross-examination, Dr. Patel conceded that the IEHP prescription histories in G.S.'s medical files were not mentioned in his report, and he stated he "could not comment" on whether the information provided in those documents was identical to the information on a CURES report. He also acknowledged that none of the referrals Dr. Schwartz made for G.S. were referenced in Dr. Patel's written report, but that his failure to reference them was "not inadvertent." Although Dr. Patel did not note G.S.'s medical conditions in his report, he claimed during his hearing testimony that he was aware of them. Dr. Patel did not agree that G.S. was receiving palliative care, but he admitted that the statement in his report that G.S. did not receive hospice care was inaccurate. Dr. Patel admitted that "opiates" are a mainstay of treating cancer pain, after being confronted with such language in the *Prescribing Guidelines*. Although Dr. Patel's report did not mention G.S.'s cancer, he did not believe his report was fatally flawed by that omission.

DR. PATEL'S OPINIONS REGARDING PATIENT E.G.

93. With regard to Dr. Schwartz's treatment of patient E.G., Dr. Patel opined in his written report that "[t]here was a **simple departure** from the standard of care for failure to follow the guidelines for Prescribing Controlled Substances as set forth by the CMB and a

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[22] Complainant's counsel painstakingly reviewed G.S. medical records with Dr. Patel for the time period from 2005 through 2010, and Dr. Patel offered opinions about treatment during that time frame, even though most of that time frame was well over seven years before the initial accusation was filed in January 2017. Opinions offered for the time period before 2010 were not considered in rendering this decision.

lack of knowledge." (Emphasis in original.) Also in the "Conclusion" portion of his written opinion regarding E.G.'s treatment, Dr. Patel wrote:

> i. . . . Dr. Schwartz's practice of pan [*sic*] management consists of 5-10% of his practice and this patient was on very high doses of pain medications and prescribed numerous pills each time. This patient was not receiving palliative care or hospice care (as described by CMS' Conditions of Participation).
>
> ii. E.G. was on high doses of oxycodone, Norco and Adderrall [*sic*] and for the last several years. However, in this case she had been referred and evaluated by other physician specialists (rheumatologist).
>
> iii. However, there should have also been consideration for the referral to interventional pain management to consider other modalities of pain management as well. She remained on a very high dose of pain medications [*sic*], receiving them for an extended period of time with high quantities.[23]

Dr. Patel's written analysis regarding Dr. Schwartz's treatment of patient E.G. did not describe E.G.'s medical conditions and read as follows:

> **b. Analysis**
>
> i. In reviewing the full medical records with regards to this patient, it does not appear that any of the available options as set forth by the CMB regarding pain management/referrals/documentation/documenting diversion/utilizing CURES consistently/specialist consultations were followed by Dr. Schwartz.
>
> ii. E.G. was referred to a rheumatologist specialist. E.G.'s pain was, therefore, conjointly managed by Dr. Schwartz and the rheumatologist.
>
> iii. However, there should have also been consideration for referral to interventional pain management to consider other modalities of pain management as well. She remained on a very high dose of pain medications [*sic*], receiving them for an extended period of time with high quantities.

[23] Paragraphs (b)(ii) and (b)(iii) did not appear in the unsigned version of Dr. Patel's report, which was also dated December 30, 2016.

94. During his testimony, Dr. Patel stated that it was important for a physician to confirm a patient's diagnosis from old records or other doctors or perform the physician's own lab work and diagnostic tests. According to Dr. Patel, it would be a departure from the standard of care to fail to do so. However, Dr. Patel did not explain whether Dr. Schwartz's referral to Dr. Zamiri was sufficient to meet the standard of care in this respect.

95. Dr. Patel was critical of Dr. Schwartz's care of E.G. because there was "not very much" as far as pain assessments in the medical records, there was no pain contract, there were no drug screens performed, and there were no notes regarding alternative treatments. Dr. Patel believed Dr. Schwartz managed E.G.'s treatment better than J.S. and E.G., and he therefore only found a simple departure from the standard of care in Dr. Schwartz's treatment of patient E.G. He did not believe E.G. was receiving palliative care because there was no "evidence" of it in the documentation.

Guidelines for Prescribing Controlled Substances for Pain

96. Dr. Patel cited the board's 2014 *Prescribing Guidelines* in his written opinion letter under the heading "Standard of Care," stating that it "requires that the physician perform the following data gathering steps. . . ."[24] Dr. Patel acknowledged during his testimony, after being confronted with specific language in the 2014 *Prescribing Guidelines'* "Preamble," that the board's *Prescribing Guidelines* do *not* mandate the standard of care and only provide recommendations.

97. The "Preamble" at the beginning of the 2014 *Prescribing Guidelines* contains the following cautionary language regarding its intended use and clarifies that it does *not* set the standard of care (pages 1-2, emphasis added):

> These guidelines are intended to help physicians improve outcomes of patient care and to prevent overdose deaths due to opioid use. They particularly address the use of opioids in the long-term treatment of chronic pain. Opioid analgesics are widely accepted as appropriate and effective for alleviating moderate-to-severe acute pain, pain associated with cancer, and persistent end-of life pain. Although some of the recommendations cited in these guidelines might be appropriate for other types of pain, they are not meant for the treatment of patients in hospice or palliative care settings and are not in any way intended to limit treatment where improved function is not anticipated and pain relief is the primary goal. These guidelines underscore the extraordinary complexity in treating pain and

[24] Although much of the conduct alleged in the first amended accusation occurred before 2014, only the 2014 revision of the *Prescribing Guidelines* was submitted during this hearing.

how long-term opioid therapy should only be conducted in practice settings where careful evaluation, regular follow-up, and close supervision are ensured. Since opioids are only one of many options to mitigate pain, and because prescribing opioids carries a substantial level of risk, these guidelines offer several non-opioid treatment alternatives. **These guidelines are not intended to mandate the standard of care. The Board recognizes that deviations from these guidelines will occur and may be appropriate depending upon the unique needs of individual patients. Medicine is practiced one patient at a time and each patient has individual vulnerabilities.** Doctors are encouraged to document their rationale for each prescribing decision. Physicians should understand that if one is ever the subject of a quality of care complaint, peer expert review will be sought by the Board. **The expert reviewer must consider the totality of circumstances surrounding the physician's prescribing practice (e.g., issues relating to access of care, paucity of referral sources, etc.) Specifically, experts are instructed to 'define the standard of care in terms of the level of skill, knowledge, and care in diagnosis and treatment ordinarily possessed and exercised by other reasonably careful and prudent physicians in the same or similar circumstances at the time in question.**[25]

Respondent's Expert Witness

98. Dr. Schwartz called Walter W. Strauser, M.D., to testify as an expert witness. Dr. Strauser is licensed to practice medicine in California and New York. He is board certified in physical medicine and rehabilitation, with a subspecialty certification in pain medicine. He is also board certified in psychiatry and is a Diplomate of the American Board of Pain Medicine and the National Board of Medical Examiners. He has been a Qualified Medical Examiner for the State of California in pain medicine, physical medicine and rehabilitation, and psychiatry since 1994.

Dr. Strauser attended the University of Notre Dame from 1974 to 1978, and Jefferson Medical College from 1978 to 1982. He did his first residency in psychiatry at New York Presbyterian Hospital, Westchester Division, from 1982 to 1986, and he did a second residency in physical medicine and rehabilitation at Stanford University Medical Center from 1986 to 1989, where he was Chief Resident during 1988. Dr. Strauser did two residencies because he was interested in the neurological aspects of psychiatry. As a result, he is now

[25] This standard of care definition is consistent with long standing California law, as is discussed further in the Legal Conclusions portion of the decision.

one of only ten other physicians in the country with a double certification in both psychiatry and physical medicine and rehabilitation.

99. Dr. Strauser has been in private practice in San Diego since 1989. He treats patients in the hospital and out of the hospital, and most of his patients are seen on an outpatient basis at his office. Dr. Strauser treats all types of chronic pain, including chronic neuralgia resulting from traumatic and non-traumatic brain injuries and spinal injuries resulting from neuro-muscular disease. He also treats psychiatric problems. Dr. Strauser noted that the vast majority of chronic pain patients also suffer from depression and anxiety. He does not treat hospice patients.

100. Dr. Strauser has also served as an expert medical reviewer for the medical board since 2004, and he has reviewed approximately 65 cases in that capacity. He has testified 15 times in medical board cases. Most of those matters involved the field of pain medicine.

PRESCRIBING GUIDELINES

101. Dr. Strauser is familiar with the board's *Prescribing Guidelines*, which has undergone several edits since 1994, with the most recent revision in November 2014. The *Prescribing Guidelines* are not mandates and are not intended to set the standard of care. The *Prescribing Guidelines* contain suggestions. Although the suggestions may be reasonable and appropriate, it is necessary to look at all the circumstances to determine appropriate treatment. The suggestions in the *Prescribing Guidelines* are all good, but they do not dictate the standard of care.

DEFINITIONS OF ADDICTION, DEPENDENCE, PALLIATIVE CARE, AND HOSPICE CARE

102. Dr. Strauser defined some terminology and concepts relevant to the facts of this case.

103. Dr. Strauser explained the difference between "addiction" and "dependence," in the context of opiates as being associated with tolerance and withdrawal. If a person continues to take opiates, he may become less sensitive and need higher doses, thereby building "tolerance." If a person abruptly stops after taking a stable dose, the person will experience "withdrawal" signs, such as nausea, perspiration, and diluted pupils. Tolerance and withdrawal define dependence. Addiction, on the other hand, is a neurological, biological, and psychological problem. Factors associated with addiction include cravings; compulsion or needing to use; multiple, unsuccessful attempts to control use; and continued use despite harm.

104. Dr. Strauser also discussed "palliative care" and "hospice care." The purpose of "palliative care" is alleviation of suffering geared toward relieving pain and improving quality of life and the ability to conduct daily activities. Palliative care is not its own sub-specialty. "Hospice care" is a team effort to help provide palliative care to terminally ill

patients with less than six months left to live. Hospice care may be provided in home or in a facility. Hospice care is devoted to alleviating suffering. A hospice care team will include doctors, nurses, social workers, and spiritual advisors to help smooth the transition to "the beyond."

Palliative care may be provided to patients who are not terminally ill. There is no standard of care that dictates the need to document the provision of palliative care when treating intractable pain. No standard of care requires a physician to document that the treatment is "palliative care." The circumstances gleaned from the patient's chart show whether the care a patient is receiving is palliative.

STANDARD OF CARE

105. Dr. Strauser explained that an "extreme departure" from the standard of care means that there was "a lack of even scant care," such that an extreme departure involves a greater deviation from the standard or care than a simple departure.

106. The standard of care requires that a medical indication must exist to prescribe dangerous drugs. During the time frame from 2010 to 2015, the standard of care required a primary care physician treating a person with a long-term course of opioids to inquire about the patient's pain levels and obtain the patient's perspective regarding the intensity of the pain. Dr. Strauser has never heard of the "PQRST" acronym used by Dr. Patel before. According to Dr. Strauser, when assessing pain during a follow-up visit, the clinician should determine the intensity of the pain, the impact on the patent's quality of life, and the impact on the patient's functioning. However, those three items do not need to be documented during every visit to meet the standard of care.

107. The necessary frequency of reassessment of a patient's pain depends on the stability of the patient. It could be every three months to once a year. When treating a high-risk patient with a substance abuse disorder, the physician might want to assess more frequently, and if doses were being adjusted, the physician might want to see the patient more often. If the patient was on a stable dose with a low risk of misuse, the physician could see the patient every six months. During 2010 through 2015, there was no specific frequency mandate, and the standard of care did not require that chronic pain patients be seen monthly.

108. Between 2010 and 2015, the standard of care required some form of monitoring of patients who were prescribed opiates for over six months. During the timeframe in question, use of urine drug analysis was not required by the standard of care, even though such drug screening has been more widely used since 2016. Pain management contracts were also not required by the standard of care, although they have been more widely embraced since 2016. Furthermore, requiring patients to bring in unused medication was not required by the standard of care.

109. The standard of care does not determine the number of pills prescribed. The standard of care does not require a pain assessment to be done at every visit. The standard of

care does not require a primary care doctor to document when he was providing a patient palliative care.

110. Every type of clinician may have a different standard of care and the standard of care may be different for a clinician practicing in San Diego than for a clinician practicing in Banning. Location may impact access to care, but it does not impact the ability to assess and document pain. From 2010 to 2015, alleviating chronic pain would be a treatment goal for all physician's, but that having pain alleviation as a goal is different than the standard of care. Having a treatment plan is a component of the standard of care and monitoring of therapy is also part of the standard of care. Documentation is also an important part of managing any patient and can vary. Whether a lack of documentation amounts to a departure from the standard of care depends on the specific circumstances. Some generalists may not be as obsessive about documentation, and the standard of care may depends on the clinician's location.

111. Documentation is separate from monitoring. A doctor may provide adequate care, but not do a good job documenting. Adequate documentation is important to understand what a doctor did at a specific time, and it may be more important for another doctor assuming care than for the treating physician. The purposes for adequate record keeping include allowing others who provide care to have accurate information, for tracking treatment history to provide optimal care, for insurance review, and for administrative review. Snapshots of levels of pain should be documented and medications prescribed should be documented.

112. Often a physician may write a prescription that is signed and dated on the date written, with the notation "Do not fill until" a specific date. However, it is improper to sign a prescription if the date of the prescription is not the actual date it is signed.

INFORMATION REVIEWED

113. Dr. Strauser reviewed all the medical records, the accusation, Dr. Patel's (signed and unsigned) reports, Dr. Patel's curriculum vitae, the subject interview, Dr. Schwartz's curriculum vitae, the CURES reports, the video of J.S. and E.G., J.S.'s declaration, and the records related to the undercover patient. He also reviewed the *Prescribing Guidelines* Dr. Patel referenced in his report.

114. Dr. Strauser explained that he needed to have an understanding of the patient's conditions in order to render opinions regarding the standard of care. He noted that it was "remarkable" that Dr. Patel's report was devoid of any mention of the patients' conditions, other than referencing G.S.'s history of heroin use and his cardiac event. There was no way for Dr. Strauser to tell from Dr. Patel's report whether he had considered or was aware of the patients' medical conditions.

DR. STRAUSER'S OPINIONS

115. In Dr. Strauser's opinion, there was no departure from the standard of care in terms of Dr. Schwartz's care and treatment of J.S., G.S., or E.G.

Dr. Strauser's Analysis of Dr. Schwartz's Treatment of J.S.

116. When Dr. Schwartz inherited J.S. as a patient, she was already taking high doses of pain medication, and she already had certain expectations, which complicated the ability to make changes. Dr. Strauser noted that although the standard of care did not require referral to a pain management specialist, Dr. Strauser did refer J.S. to a specialist, Dr. Thio. Dr. Thio switched J.S. to fentanyl patches and tried dorsal column stimulators twice, but they were unsuccessful. Dr. Schwartz also referred J.S. to Dr. Reynolds, but according to Dr. Strauser, Dr. Reynolds's report was not really coherent because it did not seem to acknowledge J.S.'s pain and did not give very helpful guidance. Dr. Schwartz discussed Dr. Reynolds's report with J.S. and tried to refer her to another specialist, but the available referrals seemed limited. When J.S. did not want to wean off the opioids, the standard of care did not require Dr. Schwartz to abandon her as a patient.

117. Dr. Strauser noted that although trigeminal neuralgia may occasionally be curable, given J.S.'s history with surgical intervention, her condition was intractable. In Dr. Strauser's opinion, palliative care was given to J.S. because she had an incurable disease and she was being treated in an effort to relieve pain and improve her quality of life and her ability to perform her daily activities. Dr. Schwartz's treatment did not depart from the standard of care for a generalist at the time in the location of his practice because Dr. Schwartz was treating a woman with a clear history of problems associated with chronic pain and legitimate medical conditions that required pain medication.

118. There was no evidence J.S. abused or diverted her medication or that she was addicted. Dr. Strauser saw no departure in the standard of care in the area of developing a treatment plan. Dr. Schwartz's monitoring of J.S.'s pain medication was within the standard of care for an internist/generalist during the time frame in question. There was also no need to do a comprehensive examination every time there was an office visit. Rather, a clinician's priorities are dictated by how a patient presents at a visit.

119. On cross-examination, Dr. Strauser stated that with a patient like J.S., it would be reasonable to reassess her pain one time a year to meet the standard of care.

120. When reviewing Dr. Schwartz's documentation of his treatment of J.S., Dr. Strauser opined that the documentation deviated from the standard of care during the time from 2010 to 2013, but it was a simple departure and did not concern J.S.'s overall care. After Dr. Schwartz changed to electronic records, his documentation significantly improved.

Dr. Strauser's Analysis of Dr. Schwartz's Treatment of G.S.

121. Dr. Strauser was critical of the portion of Dr. Patel's report regarding G.S. because it did not mention any of G.S.'s medical conditions other than his prior drug use, it incorrectly stated that Dr. Schwartz was not aware of G.S.'s prior drug use, and it failed to mention G.S.'s cancer. According to Dr. Strauser, G.S.'s cancer was a critical factor and the fact it was not referenced by Dr. Patel's report was a major oversight, particularly given that the *Prescribing Guidelines* Dr. Patel relied upon were intended for the purpose of assisting physicians treating chronic, non-cancer pain, and the *Prescribing Guidelines* state that opioids are the "mainstay" of treating cancer pain. Dr. Strauser also found Dr. Patel's statement in his report that G.S. was not receiving palliative or hospice care to be grossly inaccurate.

122. According to Dr. Strauser, based on a review of the medical records, during 2011 and 2012, G.S. was in the midst of cancer and related treatment and a high dose of opioids was appropriate due to the previous treatment for pain and G.S.'s high tolerance to treat the pain caused by his cancer. During the timeframe in question, G.S.'s cancer treatment included surgery and radiation therapy, breathing tube (tracheostomy) placement, and feeding tube placement (necessary for someone with difficulty swallowing). Dr. Schwartz's treatment plan was to provide palliative care, to improve G.S.'s quality of life and relieve his pain.

123. In Dr. Strauser's opinion, Dr. Schwartz's treatment and care of G.S. met the standard of care. Dr. Schwartz had periodic and frequent office visits with G.S., the pain management objectives were implicit from the medical records, and Dr. Schwartz used the IEHP forms and member history records to monitor G.S.'s pain and medications. There was no failure to consult specialists, as alleged by complainant, as Dr. Schwartz appropriately referred G.S. to an ENT, which led to the cancer diagnosis. Dr. Strauser also noted that it would not have been reasonable to limit or eliminate opiates for this patient when he was undergoing active cancer treatment.

124. Dr. Strauser noted that although G.S. may have agreed to use only one pharmacy, G.S.'s failure to comply was merely a technical violation of the pain agreement he signed and did not mean he was abusing or diverting drugs. Dr. Strauser explained that as the climate regarding prescribing opiates changed, there has been a reduction in production and distribution of some drugs. Those changes have made it more difficult for patients to have prescriptions filled, as sometimes a pharmacy will not fill a prescription or may limit the medications it has in stock, in part because such drugs may be more vulnerable to theft.

125. The fact that Dr. Schwartz did not refer G.S. to an orthopedic specialist was not a departure from the standard of care. G.S. had late stage liver failure, which causes lower back and abdominal pain, and the records reflected that prior imaging studies were unremarkable. Therefore, there was no reason to refer G.S. to an orthopedic specialist.

Dr. Strauser's Analysis of Dr. Schwartz's Treatment of E.G.

126. With respect to patient E.G., Dr. Strauser explained that autoimmune disease can affect every part of the body and cause pain and mental fogginess. According to Dr. Zamiri's report, E.G.'s rheumatoid arthritis involved inflammation affecting multiple joints and both sides of the body.

127. Dr. Strauser was critical of Dr. Patel's written report because it failed to mention any of E.G.'s medical conditions. He described that failure as a "glaring oversight" that rendered Dr. Patel's opinion to have limited foundation because there was no clinical context provided.

128. Dr. Strauser found no departure from the standard of care in Dr. Schwartz's treatment and care of E.G., and he pointed out that Dr. Schwartz saw the patient on a regular basis; conducted periodic pain assessments, including an initial pain assessment form and IEHP form assessments; reviewed IEHP member pharmacy records; and conducted urine drug screens.

129. On cross-examination, Dr. Strauser stated that a primary care doctor should do a pain assessment at least one time a year. The IEHP forms Dr. Schwartz completed regarding E.G. contained sufficient information to constitute an annual pain assessment in compliance with the standard of care.

Dr. Schwartz's Treatment and Care of the Patients after the Time Frames Alleged

130. Dr. Strauser reviewed Dr. Schwartz's records for the time frames after the dates alleged in the accusation. In the past three to four years, Dr. Schwartz's record keeping practices improved, and Dr. Strauser did not see any issues that he believed would require public protection.

The Undercover Operation

131. It was significant to Dr. Strauser that Dr. Schwartz did not prescribe controlled substances to the person the board sent to his office seeking medication, as Dr. Schwartz refused to prescribed opiates when there was no medical indication.

LEGAL CONCLUSIONS

Purpose of Physician Discipline

1. The purpose of the Medical Practice Act is to assure the high quality of medical practice. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.) The purpose of a disciplinary action is not to punish, but to protect the public. In an

administrative proceeding, the inquiry must be limited to the effect of the doctor's actions upon the quality of his service to his patients. (*Watson v. Superior Court* (2009) 176 Cal.App.4th 1407, 1416.) It is far more desirable to impose discipline before a licensee harms any patient than after harm has occurred. (*Griffiths v. Superior Court* (2002) 96 Cal.App.4th 757, 772.)

The Standard of Proof

2. Complainant bears the burden of proof of establishing that the charges in the accusation are true. (*Martin v. State Personnel Board* (1972) 26 Cal.App.3d 573, 583.)

3. The standard of proof in an administrative action seeking to suspend or revoke a physician's and surgeon's certificate is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

4. Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.) The requirement to prove by clear and convincing evidence is a "heavy burden, far in excess of the preponderance sufficient in most civil litigation. [Citation.]" (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.) "The burden of proof by clear and convincing evidence 'requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind.' [Citation.]" (*Ibid.*)

Statutory Disciplinary Authority

5. Business and Professions Code section 2227 provides:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

6. Business and Professions Code section 2229 provides:

(a) Protection of the public shall be the highest priority for the Division of Medical Quality, the California Board of Podiatric Medicine, and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority.

(b) In exercising his or her disciplinary authority an administrative law judge of the Medical Quality Hearing Panel, the division, or the California Board of Podiatric Medicine, shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of continuing education or other reasons, restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence.

(c) It is the intent of the Legislature that the division, the California Board of Podiatric Medicine, and the enforcement program shall seek out those licensees who have demonstrated deficiencies in competency and then take those actions as are indicated, with priority given to those measures, including further education, restrictions from practice, or other means, that will remove those deficiencies. Where rehabilitation and protection are inconsistent, protection shall be paramount.

7. Business and Professions Code section 2234, subdivisions (b) and (c), provide:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> [¶] . . . [¶]
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

8. Under Business and Professions Code section 2266, "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

Case Law Regarding Repeated Negligent Acts

9. A repeated negligent act involves two or more negligent acts or omissions. No pattern of negligence is required, repeated negligent acts means two or more acts of negligence. (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462, 468.)

Case Law Regarding Unprofessional Conduct

10. In *Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575, the appellate court noted that "unprofessional conduct" as that term was used in Business and Professions Code section 2361 (now section 2234), included certain enumerated conduct. (*Ibid.*) The court further stated (*Ibid.*):

> This does not mean, however, that an overly broad connotation is to be given the term "unprofessional conduct;" it must relate to conduct which indicates an unfitness to practice medicine. [Citations.] Unprofessional conduct is that conduct which breaches the rules or ethical code of a profession, or conduct which is unbecoming a member in good standing of a profession. [Citation.]

Nothing in *Shea* or its progeny created a new cause for discipline; the case merely defined the term as used in the Business and Professions Code.

Standard of Care

11. The law is well established that "[t]he standard of care against which the acts of a physician are to be measured is a matter peculiarly within the knowledge of experts." (*Sinz v. Owens* (1949) 33 Cal.2d 749, 753.) In *Sinz*, the California Supreme Court explained (*Ibid.*):

> The criterion in this regard is not the highest skill medical science knows; 'the law exacts of physicians and surgeons in the practice of their profession only that they possess and exercise that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of their profession under similar circumstances.' [Citation.] The proof of that standard is made by the testimony of a physician qualified to speak as an expert . . . . He must have had basic educational and professional training as a general foundation for his testimony, but it is a practical knowledge of what is usually and customarily done by physicians under circumstances similar to those which confronted the defendant charged with malpractice that is of controlling importance in determining competency of the expert to testify to the degree of care against which the treatment given is to be measured.

12. The standard of care must be provided through expert testimony. (See *Alef v. Alta Bates Hospital* (1992) 5 Cal.App.4th 208, 215-219.) The "standard of care" is the "minimum level of care to which the patient is entitled." (*Ibid.)*

13. "The party offering the expert must demonstrate that the expert's knowledge of the subject is sufficient, and the determinative issue in each case is whether the witness has sufficient skill or experience in the field so his testimony would be likely to assist" the trier of fact. (*Alef, supra,* 5 Cal.App.4th at p. 219.) The expert's qualifications must establish that he or she has "the education, training, experience, or knowledge necessary to testify to the standards to be upheld in the practice" of the profession on which he or she is opining. (*Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 947.)

14. "The law demands only that a physician or surgeon have the degree of learning and skill ordinarily possessed by practitioners of the medical profession in the same locality and that he exercise ordinary care in applying such learning and skill to the treatment of his patient. [Citations.] The same degree of responsibility is imposed in the making of a diagnosis as in the prescribing and administering of treatment. [Citations.]" (*Lawless v. Calaway* (1944) 24 Cal.2d 81, 86; *Keen v. Prisinzano* (1972) 23 Cal.App.3d 275, 279; see also, *Borrayo v. Avery* (2016) 2 Cal.App.5th 304, 310-311, regarding formulating the standard of care as that of physicians in similar circumstances rather than similar locations.) A physician is not necessarily negligent due to every "untoward result which may occur." (*Norden v. Hartman* (1955) 134 Cal.App.2d 333, 337.) A physician is negligent only where the error in judgment or lack of success is due to failure to perform any of the duties required of reputable members of the medical profession practicing under similar circumstances. (See *Black v. Caruso* (1960) 187 Cal.App.2d 195, 200-202.)

15. While a lack of ordinary care defines negligent conduct, gross negligence is defined by an error or omission that is egregious and flagrant. "Gross negligence has been said to mean the want of even scant care or an extreme departure from the ordinary standard of conduct." (*Van Meter v. Bent Construction Co.* (1946) 46 Cal.2d 588, 594; *City of Santa Barbara v. Superior Court* (2007) 41 Cal.4th 747, 753-754.)

Case Law Regarding Evaluation of Expert Opinion Testimony

16. California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reasons upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.) "Like a house built on sand, the expert's opinion is no better than the facts on which it is based. . . . [W]here the facts underlying the expert's opinion are proved to be false or nonexistent, not only is the expert's opinion destroyed but the falsity permeates his entire testimony." (*Ibid.*)

17. An expert witness "does not possess a carte blanche to express any opinion within the area of expertise. [Citation.]" *Jennings v. Palomar Pomerado Health Systems, Inc.* (2003) 114 Cal.App.4th 1108, 1117.) "Where an expert bases his conclusion upon assumptions which are not supported by the record, upon matters which are not reasonably relied upon [by] other experts, or upon factors which are speculative, remote or conjectural, then his conclusion has no evidentiary value. [Citations.]" (*Pacific Gas & Electric Co. v. Zuckerman* (1987) 189 Cal.App.3d 1113, 1135-36.)

Evaluation of Cause to Impose Discipline

18. Complainant's expert, Dr. Patel, did not seem to understand his role, as the expert, to define the standard of care applicable to Dr. Schwartz's treatment and care of J.S., G.S., or E.G. Nor did he show any comprehension that the "standard of care" was the "minimum level of care to which the patient is entitled." (See *Alef, supra,* 5 Cal.App.4th at pp. 215-219.) Instead of using his education and experience to define the standard of care, Dr. Patel pointed to the board's *Prescribing Guidelines*, even though that document

expressly stated that it did not mandate the standard of care and that the expert must define the standard of care. Dr. Patel's testimony was peppered with indications of what he did or would do in his own practice and what he thought would be "reasonable" or "nice." At times, he seemed to be making it up as he went along. Dr. Patel also contradicted himself several times when discussing what the standard of care did or did not require. Additionally, Dr. Patel's explanation of his understanding of "gross negligence" was not consistent with California law.

Dr. Patel's report, and his testimony, omitted salient details regarding the patients' medical histories and contained misstatements regarding the evidence he claimed he relied upon. Indeed, his report did not even discuss the medical conditions of any of the three patients Dr. Schwartz was treating with the pain medication. Dr. Patel came across more as an advocate than an objective and neutral expert.

Dr. Patel's testimony and his report were not helpful or credible, and it would be wholly inappropriate to afford his opinions any weight in reaching the decision this case. Accordingly, Dr. Patel's opinions were not considered in rendering this decision.

19. Respondent's expert, Dr. Strauser, articulated a clear understanding of the concept of the standard of care and his role as an expert witness. He defined the standard of care under the circumstances, and he explained the information he relied upon in rendering his expert opinions. Dr. Schwartz treated J.S., G.S., and E.G. for serious, painful, debilitating conditions, and Dr. Strauser convincingly testified that Dr. Schwartz did not depart from the standard of care in his treatment and care of each of those patients. Dr. Strauser also testified that Dr. Schwartz failed to maintain adequate records of his treatment of J.S. from 2010 through 2013.

20. Based on Dr. Strauser's opinions, and because Dr. Patel's opinions were not given any weight, complainant failed to prove by clear and convincing evidence that Dr. Schwartz committed gross negligence, committed repeated negligent acts, or engaged in general unprofessional conduct. Therefore, cause does not exist to discipline Dr. Schwartz's certificate under Business and Professions Code sections 2227 and 2234, subdivision (b), based on gross negligence (First Cause for Discipline); cause does not exist to discipline Dr. Schwartz's certificate under Business and Professions Code sections 2227 and 2234, subdivision (c), based on repeated negligent acts (Second Cause for Discipline); and cause does not exist to discipline Dr. Schwartz's certificate under Business and Professions Code sections 2227 and 2234 based on general unprofessional conduct (Fourth Cause for Discipline).

21. Complainant proved by clear and convincing evidence, through Dr. Strauser's testimony, that Dr. Schwartz failed to maintain adequate medical records in his care and treatment of J.S. during the timeframe from 2010 through 2013. Accordingly, cause exists to discipline Dr. Schwartz's certificate under Business and Professions Code sections 2227, 2234, and 2266, based on Dr. Schwartz's failure to maintain adequate medical records (Fourth Cause for Discipline).

Manual of Disciplinary Guidelines

22. The Medical Board has adopted a Manual of Model Disciplinary Orders and Disciplinary Guidelines (12th Edition, 2016) which provides:

> Business and Professions Code section 2229 mandates protection of the public shall be the highest priority for the Medical Board and for the Administrative Law Judges of the Medical Quality Hearing Panel. Section 2229 further specifies that, to the extent not inconsistent with public protection, disciplinary actions shall be calculated to aid in the rehabilitation of licensee. . . .
>
> [¶] . . . [¶]
>
> The Board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake Board-ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the Board . . . will follow the guidelines, including those imposing suspensions. Any proposed decision . . . that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

23. Under the board's disciplinary guidelines, the maximum penalty for failure to maintain adequate medical records is revocation and the minimum recommended penalty is revocation stayed, with five years' probation under appropriate terms and conditions.

The Appropriate Measure of Discipline Under the Facts of this Matter

24. In this case, Dr. Schwartz's inadequate record keeping occurred from 2010 through 2013. He converted to electronic medical records in early 2012. Since he began using electronic records, his medical records provided considerably more detail and have improved. The expert testimony in this matter supported the conclusion that his most recent, 2015 through 2017, medical records were adequate. Therefore, public protection does not require a period of probation and supervision in this matter. Instead, a letter of public reprimand, with a requirement that Dr. Schwartz complete a board approved medical record keeping course, will serve to rehabilitate and educate Dr. Schwartz and is not inconsistent with public protection.

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ORDER

1. Respondent Stanley Schwartz, M.D., shall receive a written public reprimand for his failure to adequately maintain medical records, and he shall complete an approved medical record keeping course as provided below. Should the board so elect, this decision shall serve as the public reprimand.

2. **Medical Record Keeping Course.** Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in medical record keeping approved in advance by the board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course no later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of this Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the board or its Designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee no later than 15 calendar days after successfully completing the course, or no later than 15 calendar days after the effective date of the Decision, whichever is later.

DATED: November 6, 2017

Theresa M. Brehl

THERESA M. BREHL
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **STANLEY SCHWARTZ, M.D.** 12980 Frederick Street Suite I Moreno Valley, CA 92553 Physician's and Surgeon's Certificate No. A42271, **Respondent.**	Case No. 800-2014-002348 OAH Case No. 2017031119 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about November 12, 1985, the Board issued Physician's and Surgeon's Certificate No. A42271 to Stanley Schwartz, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2019, unless renewed.

JURISDICTION

3. This First Amended Accusation, which supersedes the Accusation filed on January 12, 2017 in the above-entitled matter, is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

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5. Section 2234 of the Code states, in pertinent part:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"..."

6. Unprofessional conduct under Section 2234 of the Code is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Bd. of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

7. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent has subjected his Physician's and Surgeon's Certificate No. A42271 to disciplinary action under Sections 2227 and 2234, as defined by Section 2234, subdivision (b), of the Code, in that Respondent committed gross negligence in his care and treatment of patients J.S. and G.S., as more particularly alleged below:[1]

Patient J.S.

9. On or about January 4, 2006, Respondent began treating patient J.S. for, among other things, trigeminal neuralgia and right-side posterior head and neck pain. Over the years, Respondent prescribed patient J.S. various controlled substances, including but not limited to, varying amounts of Morphine,[2] Hydromorphone,[3] Norco,[4] Vicodin,[5] and Percocet.[6] Over the years, Respondent continued to prescribe patient J.S. high levels of opiates to achieve adequate pain relief.

10. Beginning around January 2006, Respondent had contact with patient J.S. on a regular basis, averaging every four weeks. Between January 2006 and July 2015, Respondent saw patient J.S. approximately 40 times.

11. In or about March 2006, Respondent requested a consultation from A.T., M.D., a pain management specialist. On or about March 13, 2006, A.T., M.D. examined patient J.S. and recommended that Respondent discontinue prescribing Hydromorphone for patient J.S.

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[1] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

[2] Morphine sulfate, brand name MS Contin, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(L), and a dangerous drug pursuant to Business and Professions Code section 4022.

[3] Hydromorphone, brand name Dilaudid, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(J), and a dangerous drug pursuant to Business and Professions Code section 4022.

[4] Norco is the brand name for a combination of hydrocodone and acetaminophen. Hydrocodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(I), and a dangerous drug pursuant to Business and Professions Code section 4022.

[5] Vicodin is the brand name for a combination of hydrocodone and acetaminophen.

[6] Percocet is the brand name for a combination of oxycodone and acetaminophen. Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug pursuant to Business and Professions Code section 4022.

12. Between on or about January 22, 2010, through on or about December 31, 2013, Respondent prescribed patient J.S. approximately 45 prescriptions of four (4) mg Hydromorphone for a total of 27,000 tablets. Respondent was prescribing patient J.S. approximately 600 tablets of Hydromorphone every month, for an average of 20 tablets a day.

13. On or about May 21, 2014, over eight (8) years after he started treating patient J.S., Respondent gave patient J.S. another referral to see a pain management specialist.

14. On or about January 24, 2014, pain specialist L.R., M.D., recommended that patient J.S. be taken off opioids because she had not experienced pain for trigeminal neuralgia in six (6) months.

15. Following L.R., M.D.'s recommendation to take patient J.S. off opiate medications, Respondent continued to prescribe Morphine to patient J.S. Between on or about April 3, 2014, through on or about July 14, 2015, Respondent prescribed patient J.S. approximately 12 prescriptions of 30 mg Morphine for a total of 2,880 tablets. Respondent was prescribing patient J.S. approximately 240 tablets of Morphine every month, for an average of eight (8) tablets a day.

16. From 2006 through 2015, Respondent continued to prescribe high doses of opioids without any clear treatment plan and with two recommendations from pain specialists that patient J.S. discontinue her opioid medications. Respondent's progress notes for his visits with patient J.S. did not contain any clear objectives for treatment while Respondent continuously prescribed high doses of opioid medications to patient J.S.

17. Respondent committed gross negligence in his care and treatment of patient J.S., which included, but was not limited to, the following:

(a) Paragraphs 9 through 16, above, are hereby incorporated by reference as if fully set forth herein;

(b) Respondent failed to develop and document an adequate treatment plan and objectives, or conduct ongoing review and monitoring while prescribing opioids for an extended period of time; and

(c) Respondent failed to abide by the recommendation of a pain management specialist in 2014 to reduce or eliminate patient J.S.'s opiate use.

Patient G.S.

18. On or about July 21, 2004, Respondent began treating patient G.S. for, among other things, lumbago, neuropathy, and anxiety disorder. Patient G.S. was a known former heroin addict. Over the years, Respondent prescribed patient G.S. various controlled substances, including but not limited to, varying amounts of Morphine,[7] Fentanyl,[8] Valium,[9] Norco, Dilaudid, Xanax,[10] Ativan,[11] and Ambien.[12]

19. Between on or about February 7, 2011, through on or about November 2, 2012, Respondent prescribed patient G.S. approximately 10 prescriptions of Fentanyl for a total of 100 patches ranging from 25 mcg to 100 mcg. On or about November 2, 2012, Respondent prescribed patient G.S. ten (10) 100 mcg and ten (10) 50 mcg Fentanyl patches for a 30-day period.

20. Between on or about February 7, 2011, through on or about November 23, 2011, Respondent prescribed patient G.S. approximately eight (8) prescriptions of 100 mg Morphine or 100 mg Kadian for a total of 2,310 tablets or capsules.

21. On or about March 3, 2011 through on or about November 10, 2011, Respondent prescribed patient G.S. approximately six (6) prescriptions of 10 mg Valium for a total of 720 tablets.

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[7] Morphine, brand name Kadian, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(L), and a dangerous drug pursuant to Business and Professions Code section 4022.

[8] Fentanyl, brand name Duragesic, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(8), and a dangerous drug pursuant to Business and Professions Code section 4022.

[9] Diazepam, brand name Valium, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(9), and a dangerous drug pursuant to Business and Professions Code section 4022.

[10] Alprazolam, brand name Xanax, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(1), and a dangerous drug pursuant to Business and Professions Code section 4022.

[11] Lorazepam, brand name Ativan, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(16)), and a dangerous drug pursuant to Business and Professions Code section 4022.

[12] Zolpidem, brand name Ambien, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(32), and a dangerous drug pursuant to Business and Professions Code section 4022.

22. Between on or about May 17, 2012, through on or about August 27, 2012, Respondent prescribed patient G.S. approximately three (3) prescriptions of four (4) mg Dilaudid, for a total of 600 tablets.

23. Between on or about May 2, 2012, through on or about December 10, 2012, Respondent prescribed patient G.S. approximately four (4) prescriptions of 10 mg/325 mg Norco for a total of 880 tablets.

24. On or about May 2, 2012, Respondent prescribed patient G.S. one (1) prescription of 1 mg Ativan for a total of 120 tablets.

25. On or about September 19, 2012, Respondent prescribed patient G.S. one (1) prescription of 80 mg Oxycontin for a total of 90 tablets.

26. On or about July 11, 2012 through on or about November 1, 2012, Respondent prescribed patient G.S. approximately three (3) prescriptions of 2 mg Xanax, for 90 tablets each and five (5) refills, for a total of 720 tablets.

27. From 2011 through 2012, Respondent continued to prescribe high doses of opioids without any clear treatment plan. Respondent's progress notes for his visits with patient G.S. did not contain any clear objectives for treatment, or any clear inquiry or documentation by Respondent of the use of CURES or any other risk assessment tools that may have assessed the risk of aberrant behaviors by patient G.S., while Respondent continuously prescribed high doses of opioid medications in combination with benzodiazepines to patient G.S. Respondent also did not consult with any other physician specialists with regards to the sources of patient G.S.'s pain or patient G.S.'s pain management treatment.

28. Respondent committed gross negligence in his care and treatment of patient G.S., which included, but was not limited to, the following:

(a) Paragraphs 18 through 27, above, are hereby incorporated by reference as if fully set forth herein;

(b) Respondent failed to develop an adequate treatment plan, discuss treatment goals, or conduct ongoing monitoring while prescribing opioid medications; and

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(c) Respondent failed to consult with other specialists to focus on the source of patient G.S.'s pain or to reduce or eliminate patient G.S.'s opiate use.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

29. Respondent has further subjected his Physician's and Surgeon's Certificate No. A42271 to disciplinary action under Sections 2227 and 2234, as defined by Section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of patients J.S., G.S., and E.G., as more particularly alleged hereinafter:

Patient J.S.

30. Respondent committed repeated negligent acts in his care and treatment of patient J.S., which included, but was not limited to, the following:

(a) Paragraphs 9 through 17, above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

Patient G.S.

31. Respondent committed repeated negligent acts in his care and treatment of patient G.S., which included, but was not limited to, the following:

(a) Paragraphs 18 through 28, above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

Patient E.G.

32. On or about January 12, 2011, Respondent began treating patient E.G. for, among other things, lupus, rheumatoid arthritis, and lumbago. Over the years, Respondent prescribed patient E.G. various controlled substances, including but not limited to, Norco, Oxycodone,[13] Adderall,[14] Ambien,[15] and Xanax.

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[13] Oxycodone, brand name Oxycontin, is a Schedule II controlled substance pursuant to Health and Safety Code section 11057, subdivision (b)(1)(M), and a dangerous drug pursuant to Business and Professions Code section 4022.

[14] Amphetamine, brand name Adderall, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d)(1), and a dangerous drug pursuant to Business and Professions Code section 4022.

[15] Zolpidem, brand name Ambien, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(32), and a dangerous drug pursuant to Business and

(continued...)

33. Between on or about January 12, 2011, through on or about December 22, 2013, Respondent prescribed patient E.G. approximately 35 prescriptions of 10/325 mg Norco for a total of 11,790 tablets. On average, Respondent was prescribing patient E.G. approximately 360 tablets every month, for an average of 12 tablets a day.

34. Between on or about January 12, 2011, through on or about December 22, 2013, Respondent prescribed patient E.G. approximately 32 prescriptions of 80 mg Oxycodone for a total of 2,460 tablets. On average, Respondent was prescribing patient E.G. approximately 60 to 90 tablets every month, for an average of two (2) to three (3) tablets a day, in addition to patient E.G.'s Norco prescription.

35. Between on or about January 12, 2011, through on or about December 22, 2013, Respondent prescribed patient E.G. approximately 13 prescriptions of two (2) mg Xanax for a total of 2,040 tablets.

36. Between on or about January 12, 2011, through on or about December 22, 2013, Respondent prescribed patient E.G. approximately 31 prescriptions of five (5) or 15 mg Adderall for a total of 1,860 tablets.

37. Between on or about January 12, 2011, through on or about December 22, 2013, Respondent prescribed patient E.G. approximately five (5) prescriptions of 10 mg Ambien for a total of 480 tablets.

38. Respondent committed repeated negligent acts in his care and treatment of patient E.G., which included, but was not limited to, the following:

(a) Paragraphs 32 through 37, above, are hereby incorporated by reference as if fully set forth herein;

(b) Respondent failed to develop and document an adequate treatment plan and objectives, or conduct ongoing review and monitoring while prescribing opioids for an extended period of time; and

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(...continued)
Professions Code section 4022.

(c) Respondent failed to document or consider other modalities of pain management.

THIRD CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

39. Respondent has further subjected his Physician's and Surgeon's Certificate No. A42271 to disciplinary action under Sections 2227 and 2234 of the Code, in that Respondent has engaged in conduct which breached the rules or ethical code of the medical profession or which was unbecoming of a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, in his care and treatment of patients J.S., G.S., and E.G., as more particularly alleged in paragraphs 9 through 38, and 40, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

40. Respondent has further subjected his Physician's and Surgeon's Certificate No. A42271 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate medical records in his care and treatment of patient J.S., as more particularly alleged in paragraphs 9 through 17, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

PRAYER

WHEREFORE, complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A42271, issued to Respondent, Stanley Schwartz, M.D.;

2. Revoking, suspending or denying approval of Respondent, Stanley Schwartz, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code, and advanced practice nurses;

3. Ordering Respondent, Stanley Schwartz, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: October 4, 2017

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant